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THESIS

ADDING A PRESCRIPTION DRUG BENEFIT TO MEDICARE: AN ANALYSIS OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

by

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September 2004

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added an outpatient prescription drug benefit to Medicare. This benefit had been a recurring topic among lawmakers, attempted many times since Medicare was enacted in 1965. The 2003 legislation marked the most significant and expensive overhaul of Medicare since its creation. It occurred at a time of record federal budget deficits and Republican control of Congress and the White House. The major compromise that allowed this legislation to succeed concerned the total funding to be made available, the amount of privatization in the design and administration of the benefit, and the scope of the coverage. This thesis identifies and describes the primary stakeholders involved and their influences on the benefit, including political parties, Congress, the Bush Administration and interest groups, and summarizes previous attempts at similar legislation. Sources include congressional testimony, government cost estimates, legislation, journal articles, and think-tanks. The thesis analyzes the legislative process that produced the Medicare reform and identifies problems and issues resulting from it.

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ADDING A PRESCRIPTION DRUG BENEFIT TO MEDICARE: AN ANALYSISIS OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

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ABSTRACT

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added an outpatient prescription drug benefit to Medicare. This benefit had been a recurring topic among lawmakers, attempted many times since Medicare was enacted in 1965. The 2003 legislation marked the most significant and expensive overhaul of Medicare since its creation. It occurred at a time of record federal budget deficits and Republican control of Congress and the White House. The major compromise that allowed this legislation to succeed concerned the total funding to be made available, the amount of privatization in the design and administration of the benefit, and the scope of the coverage. This thesis identifies and describes the primary stakeholders involved and their influences on the benefit, including political parties, Congress, the Bush Administration and interest groups, and summarizes previous attempts at similar legislation. Sources include congressional testimony, government cost estimates, legislation, journal articles, and think-tanks. The thesis analyzes the legislative process that produced the Medicare reform and identifies problems and issues resulting from it.

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I. INTRODUCTION

A. PURPOSE

This thesis will study the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law by President George W. Bush on December 8, 2003, which amended title XVIII of the Social Security Act. Specifically, the thesis will focus on the addition of a prescription drug benefit to Medicare. Analyzed in this thesis will be the legislative process the bill followed in the first session of the 108th Congress, the influence of party politics and special interest groups on the bill, the major concerns of policy makers associated with the addition of the benefit, the provisions finally approved in Public Law 108-173, and issues that continue to be discussed by the second session of the 108th Congress.

B. RESEARCH QUESTIONS

The primary question answered by this thesis is:

- What were the major policy compromises underlying the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the major problems that have been identified subsequent to the passage?

The subsidiary questions explained and answered by this thesis are:

- What was the primary problem addressed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003?
- What were the positions taken by the major participants involved with the bill's creation and passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, i.e., the political parties, the interest groups, the White House, the Senate, and the House?

- What were the major provisions of the prescription drug benefit in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003?
- What compromises were reached to allow passage and presidential approval?
- What policy problems associated with the legislation have emerged in the second session of the 108th Congress?

C. DISCUSSION

A top priority of the Bush Administration was to strengthen and improve Medicare by expanding benefits and ensuring it will be available for future generations. The Administration allocated $400 billion over a ten-year period in the fiscal year 2004 President's Budget for the reforms. The most significant improvement to Medicare was the availability of a prescription drug benefit.

The budget for FY2004 was not the first time a prescription drug benefit or other reforms were attempted to change Medicare. Congress had been debating legislation for the expansion and reform of Medicare since the Clinton Administration. Both the House and the Senate introduced bills for FY2000 to provide outpatient prescription drugs to Medicare beneficiaries, but the Clinton budget did not include a plan for Medicare reform, and the bills were not passed by either side of Congress. The FY2001 budget submitted by President Clinton in February of 2000 had a prescription drug benefit proposal of $100 billion, covering the period between 2003 and 2010. During this second session of the 106th Congress, the House passed H.R. 4680 in June of 2000 that provided for a voluntary program for prescription drug coverage under the Medicare Program,

as well as additional Medicare reforms. The bill was introduced in the Senate, and no further action was taken.

President Bush's first budget for FY2002 had an amount of $153 billion over ten years for Medicare modernization and reform, to include a prescription drug benefit. No bills were passed by the first session of the 107th Congress. The FY2003 budget submitted by President Bush included $190 billion over ten years for Medicare modernization and prescription drug benefits. During this second session of the 107th Congress, the House passed H.R. 4954 that provided for voluntary prescription drug coverage and reformed the payment and regulatory structure of the Medicare Program. The bill was received in the Senate where it was not considered for further action.

In June of 2003, two bills were introduced in Congress, one each in the House of Representatives and the Senate, to address the President's budget request. Debate and compromise surrounded the two bills between June and November of 2003. A Conference Report was agreed to at the end of November by both sides, the final version of the bill was presented to the President, and it was signed into law on December 8, 2003, making Public Law 108-173 the most significant and expensive change to Medicare since its establishment in 1965.

D. SCOPE OF THE THESIS

This thesis will provide a background on the Medicare system, explain the major issues to consider in the design of a prescription drug benefit, discuss the major sources of controversy within the debate on the prescription drug benefit, investigate how the issues were resolved, and how special interest groups influenced the passage of the bill.

Furthermore, it will describe the provisions of the prescription drug benefit, examine the cost estimates of the benefit, and discuss issues that were unresolved, and are being debated by Congress during its second session in 2004.

E. METHODOLOGY

The methodology used in the research for this thesis consists of a review of appropriate literature and cost estimates by the Office of Management and Budget, a review of legislation introduced in Congress, testimony brought before Congress, literature and cost estimates by the Congressional Budget Office, a review of literature and cost estimates from the Department of Health and Human Services, a review of literature and audits performed by the Government Accountability Office, and a review of literature available from special interest groups, research foundations, and think-tanks.

F. ORGANIZATION

Chapter II provides an introduction to Medicare and its components, gives an overview of the Medicare Trust Fund and how Medicare is financed, and provides a summary of the major Medicare policy changes since its creation. The chapter continues with a discussion of the major fiscal challenges facing Medicare, and trends in national healthcare and prescription drug spending. The chapter ends with a discussion of the reasons for adding a prescription drug benefit to the Medicare program and factors to consider when designing prescription drug coverage.

Chapter III introduces recent attempts by the President and Congress to add outpatient drug benefits to Medicare. It discusses recent actions of Congress to create

a prescription drug benefit, compares the different views of various stakeholders, such as Republicans and Democrats, in creating the benefit, and discusses other special interest groups, and their influences. The chapter concludes with an introduction to President Bush's Proposal for Medicare reform and prescription drug coverage in 2003.

Chapter IV discusses the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the process and evolution of the bill in Congress, the major compromises underlying the prescription drug benefit, the primary provisions of the legislation, and the controversy surrounding the bill.

Chapter V examines the fiscal impacts of the bill on the Medicare trust fund and beneficiaries, and discusses changes to the bill debated in the second session of the 108th Congress. It also summarizes the issues presented in the previous chapters regarding the Medicare prescription drug benefit and concludes with recommendations for follow-on studies.

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II. BACKGROUND

A. MANDATORY SPENDING AND ENTITLEMENTS

The federal government divides its budget into two main categories: discretionary and mandatory spending. Mandatory spending consists of benefit programs such as Social Security, Medicare, and Medicaid. These programs are also referred to as entitlements. Congress generally determines spending for entitlement programs by setting rules for eligibility, benefit formulas, and other parameters, rather than by appropriating specific dollar amounts each year (Congressional Budget Office [CBO], January 2004, p. 48). In short, the government is required to pay for benefits claimed under these programs. Figure 2.1 shows federal spending for mandatory and discretionary programs for select years, 1962, 1982, and 2002. Medicare and Medicaid did not exist in 1962, and the large increase in mandatory spending resulting from their establishment is illustrated in this figure. Figure 2.2 shows how much of the federal budget went towards specific spending categories, including the big three entitlement programs, during the same years. Defense and other discretionary spending have decreased while Social Security, Medicare and Medicaid have increased their share of federal spending.

B. INTRODUCTION TO MEDICARE AND MEDICARE TRUST FUNDS

Medicare is a national health insurance program for the elderly and certain disabled people. President Harry S. Truman first proposed its creation in 1945 in a special message to Congress calling for a comprehensive, prepaid medical insurance plan accessible to all elderly, and financed through the Social Security system and federal

revenues (Centers for Medicare and Medicaid [CMS] Website, July 2004). The American Medical Association immediately blasted the Truman administration, and squelched all attempts at legislation by Truman's Congressional allies for what was called "socialized medicine."

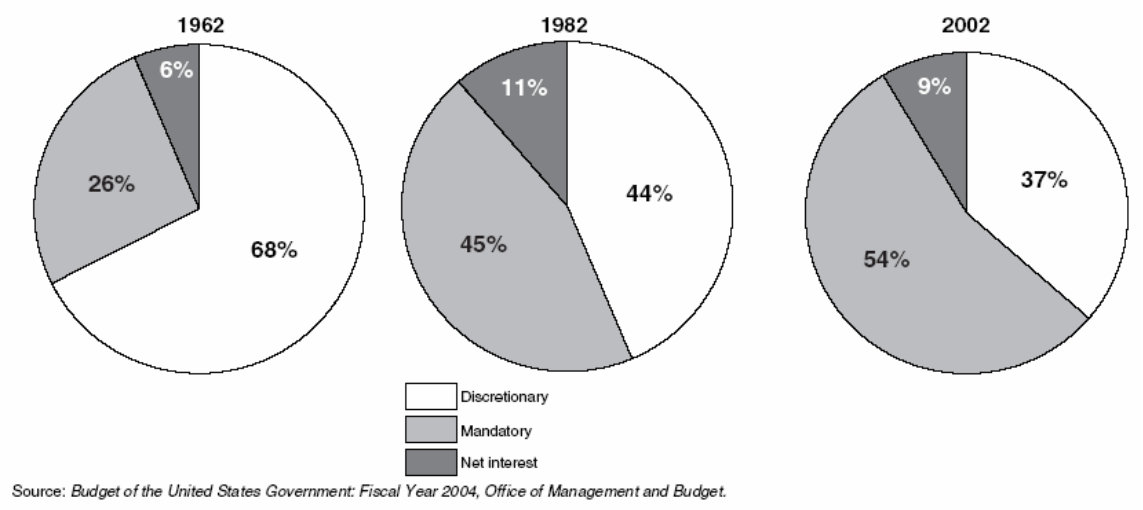


Figure 2.1. Analysis of Federal Spending for Mandatory and Discretionary Programs in 1962, 1982, and 2002. (From Walker, 2003, p.11).

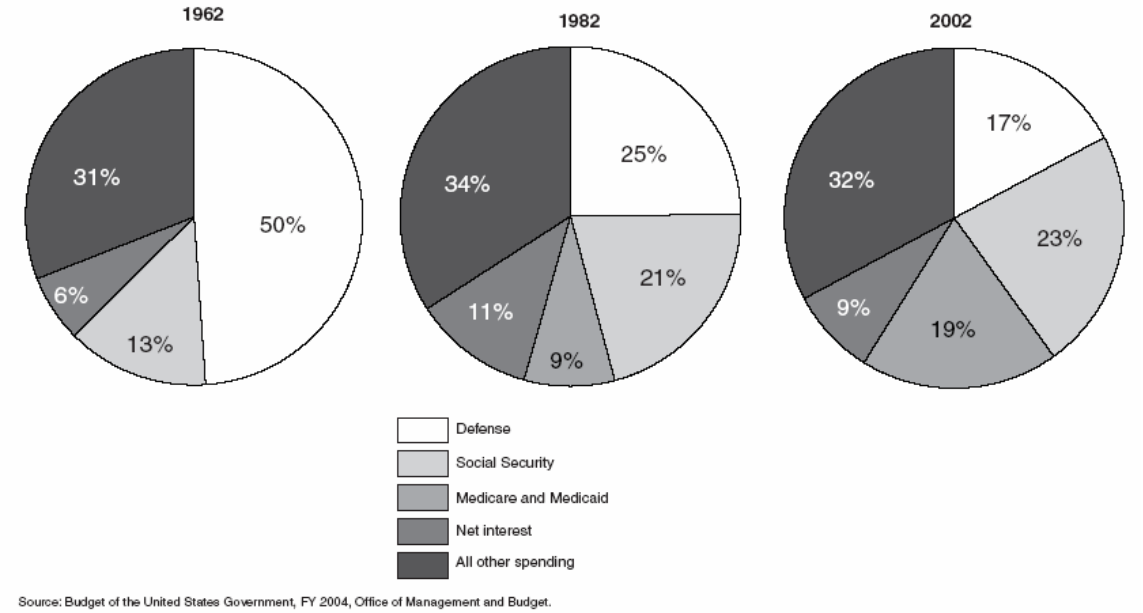


Figure 2.2. Structure of Federal Spending by Budget Category in 1962, 1982, 2002. (From Walker, 2003, p.10).

The idea was proposed again in 1951 by the head of the Federal Security Administration (now the Social Security Administration), and between 1958 and 1965 Congress held annual hearings for health insurance proposals for the elderly.

1. Medicare Enacted

In 1964 President Lyndon B. Johnson was elected by a landslide, and a large shift to a Democratic majority in Congress also occurred. Legislation for Medicare in 1964 consisted of a Democratic proposal called the King-Anderson bill, and a Republican-supported proposal called the Byrnes bill. The King-Anderson bill mainly included coverage for hospitalization in a universally available social insurance plan. The Republican proposal was a voluntary program that was financed by premiums paid by the beneficiaries and subsidies from the Treasury's general fund. The Byrnes bill included benefits for physician services and prescription drug coverage.

In March of 1965, a compromise between the Democrats and Republicans joined the two bills, and it was sent to the House Ways and Means committee for mark up. The result was Title XVIII amending the Social Security Act of 1935, and was composed of Medicare Part A or Hospital Insurance, and Medicare Part B or Supplemental Medical Insurance. The resulting legislation excluded one benefit that was proposed by the Byrnes bill due to supposedly unpredictable and potentially high costs (Marmor, 2000). The missing benefit was outpatient prescription drug coverage. On July 30th, President Johnson signed Title XVIII into law. On July 1st of the following year, nineteen million elderly Americans enrolled in Medicare (CMS Website, July 2004).

In 1972, Medicare was expanded to allow the disabled and those with permanent kidney failure to enroll in the program. Two million more beneficiaries were allowed to enroll in Medicare that year (CMS Website, July 2004).

2. Medicare Components

Because of the two proposals that were combined to create Medicare in 1965, Medicare services were divided into two components.

a. Medicare Part A: Hospital Insurance (HI)

Medicare Part A is also known as the Hospital Insurance (HI) program. It covers almost all Americans aged 65 or older, disabled persons receiving Social Security or Railroad Retirement benefits, and people with end-stage renal disease (ESRD) (Office of Management and Budget [OMB], 1999). A small number of people aged 65 or older are not eligible for Medicare Part A because they or their spouses never paid Medicare taxes; however, Part A is available to these people if they pay a monthly premium. Coverage provided by Medicare Part A includes costs associated with inpatient hospital stays, services provided by skilled nursing facilities, home health care, and hospice services. Inpatient prescription drugs are also covered in Part A of Medicare.

Part A reimbursement is provided by the Hospital Insurance (HI) Trust Fund. The HI Trust Fund is financed primarily by a 2.9-percent payroll tax on working Americans' earnings, split between employers and employees at 1.45 percent each. The payroll tax accounts for approximately 90 percent of the HI Trust Fund revenues, and taxes collected each year are used to pay the hospital benefits of current beneficiaries. The HI Trust Fund is

also funded by interest on trust fund investments, premiums of non-invested beneficiaries, deductibles and coinsurance, and income taxes on social security benefits (Medicare Payment Advisory Committee [MedPAC], 2004, p. 71). Revenues for Part A of Medicare are highly dependent on the number of working Americans, as well as how much they earn.

b. Medicare Part B, Supplemental Medical Insurance (SMI)

The Supplemental Medical Insurance (SMI), or Medicare Part B, covers services provided by physicians, outpatient hospital care, and suppliers of medical equipment. Part B coverage is optional, and is available to those who are also entitled to Part A. Approximately 95 percent of those enrolled in Part A also opt for Part B.

Financing for Part B differs from Part A in that enrollees are required to pay monthly premiums if they choose to participate in Part B coverage. The premiums account for about 25 percent of the Part B costs, and most beneficiaries pay their Part B premiums as deductions from their Social Security earnings. Also unlike the HI Trust Fund, the SMI trust fund is directly connected to the general fund of the U.S. Treasury. The majority of the remaining 75 percent of trust fund obligations are subsidized by general taxpayer dollars.

c. The HI and SMI Trust Funds

Unlike private trust funds, federal trust funds are not channels to set aside savings for the future. They are primarily budget accounting mechanisms used to record revenues and expenses earmarked for specific purposes.

As mentioned previously, the HI and SMI trust funds are financed in completely different ways. HI trust

fund financing must remain separate from general revenues, and payroll taxes cannot be increased or decreased without passage of legislation to change the tax rate. For the SMI trust fund, premiums and general revenue financing are reestablished annually to match expected costs for the following year (Boards of Trustees, 2004, p. 6).

Additionally, current law requires that if a federal trust fund like the HI trust fund runs a surplus of payroll tax receipts over benefit payments, that surplus must be invested in Treasury securities and used to meet current cash needs of the government. These securities are considered to be reserves, and are an asset to the trust fund. When a trust fund runs a cash deficit, it redeems these securities to pay benefit expenses exceeding current payroll tax proceeds (Walker, 2003, p. 4). If the HI trust fund runs a cash deficit (benefit expenses exceed payroll tax revenues) for an extended period of time, and the securities become exhausted, the trust fund is deemed insolvent.

Because SMI receives 75 percent of its funds from general revenues, and annual adjustments are made to the general revenue and premium amounts expected to cover SMI expenses, financing for SMI is always projected to meet costs (Boards of Trustees, 2004, p. 13). Later in this chapter the historical expenditures and projected costs associated with Medicare Part B and its impact on the general funds as it relates to the Gross Domestic Product will be discussed.

C. FISCAL CHALLENGES FACING MEDICARE

It is important to understand the situation Congress faced when it was tasked by President Bush to modernize Medicare, and to include outpatient prescription drug coverage. While Medicare reforms impacted the future of both the HI and SMI trust funds, the prescription drug benefit primarily impacted the SMI trust fund.

1. Trends Impacting Medicare

The major impacts on the future of Medicare are shifts in the demographic composition of the United States population, the increase in per beneficiary utilization of Medicare services, and nationwide increases in expenditures on healthcare services. Some of these trends are not necessarily unique to Medicare, but are issues facing society and the economy as a whole (Holtz-Eakin, April 2003, p.1).

a. Demographic Shifts

The number of beneficiaries eligible for Medicare and their relationship to the number of working Americans impacts both the HI and SMI trust funds. Since its creation, the number of Medicare beneficiaries has increased, from 19,108,822 in 1966 to 41,086,981 in 2003, for a total increase of 115 percent (CMS Website, July 2004).

The number of beneficiaries will grow significantly with the pending eligibility of the 'baby boom' generation, which analysts define as those born between 1946 and 1965. Baby boomers will start becoming eligible for Medicare in 2010 (Boards of Trustees, 2004, p.7). Figure 2.3 depicts the total number of beneficiaries enrolled in Medicare since 1970 with projections to 2080.

In 2010, the expected number of beneficiaries climbs to 46,592,000. By 2030, the number of beneficiaries is projected to more than double current enrollment at 79,063,000 (Boards of Trustees, 2004, p.27).

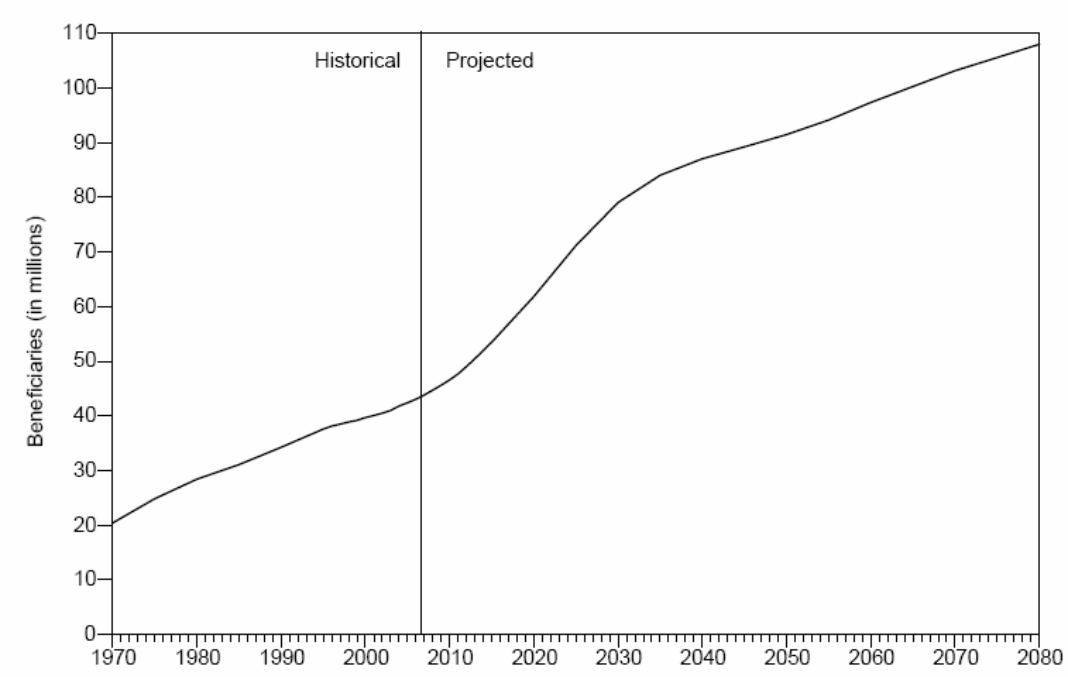


Figure 2.3. Medicare Enrollment 1970–2080. (From MedPAC, 2004, p.6).

As the baby boom generation begins to retire and become eligible for Medicare, there will be an increase in the share of elderly in the population, and the ratio of workers to beneficiaries will decrease. Some reasons for the demographic shift are a lower fertility rate, earlier retirement ages, and longevity. In the 1960s, the birth rate was three children to each woman. In 2003 the number was estimated at just over two children, and the projected birth rate in 2030 is 1.95 children (Walker, 2003, p. 6). Figure 2.4 shows the ratio of workers to HI beneficiaries from 1970 projected to 2070. In 1970 there were 4.6 American workers to each beneficiary, and in 2000 the ratio

shrunk to 4.0. When the baby boomers begin to retire in 2010, the relative number of working-age Americans to beneficiaries is projected to decrease to 3.7, and shrink even further to 3.0 workers by 2030. The ratio of working-age Americans to those in retirement has a significant impact on the financing of both Medicare and Social Security. As mentioned earlier, the HI Trust Fund is financed by a tax of 1.45 percent of each worker's paycheck. If the number of workers relative to beneficiaries decreases, there will be less revenue for the HI Trust Fund.

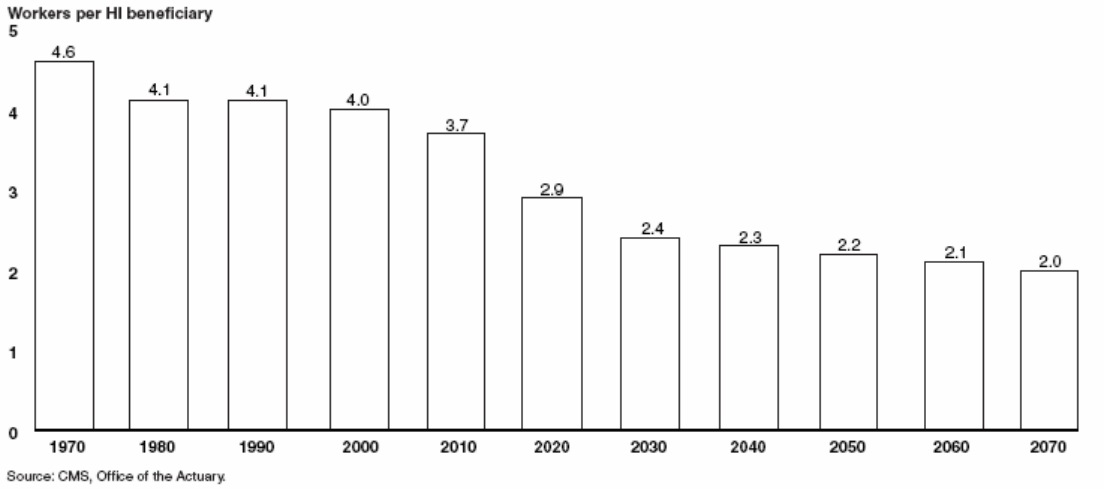


Figure 2.4. Ratio of Workers to Beneficiaries. (From Walker, 2003, p.5).

This ratio also impacts the SMI Trust Fund. If the ratio of workers to beneficiaries decreases, there are relatively fewer workers contributing to the general fund through income tax revenues, and there are relatively more Medicare beneficiaries drawing from the SMI Trust Fund. The increases in SMI Trust Fund outlays will be a larger share of the federal income, and an increased burden on the federal budget. This trend impacts the solvency of the HI trust fund and the sustainability of the SMI trust fund.

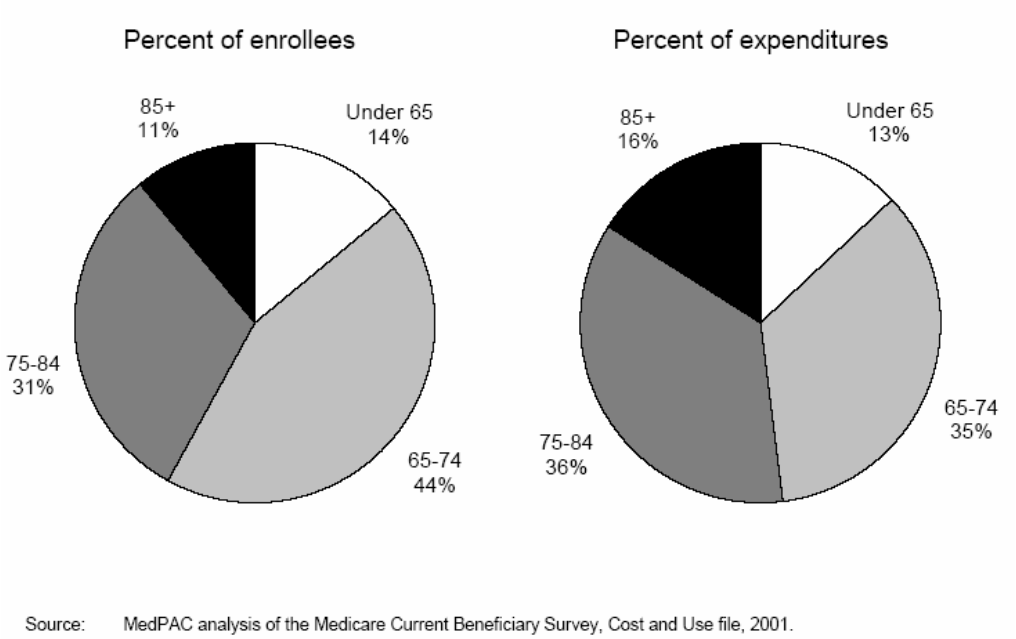
b. Per Beneficiary Utilization

In addition to the growing number of beneficiaries eligible for Medicare once the baby boom generation begins to turn 65, the average age of Medicare beneficiaries is also increasing. Retirees are living longer, a trend dubbed the "aging of society." One impact of the longevity of beneficiaries is a higher per- person utilization of Medicare services. The impact is a result of the fact that older beneficiaries use a higher percentage of services than younger beneficiaries. Table 2.1 illustrates the break out of Medicare enrollment based on the age of beneficiaries. Since 1966, the percentage of enrolled beneficiaries aged 75 and older has steadily increased, while the percentage of beneficiaries aged 65 to 74 has decreased. This trend leads to increases in Medicare expenditures per enrollee. Figure 2.5 illustrates that older beneficiaries account for a disproportionate percentage of expenditures. Beneficiaries aged 85+ account for only 11 percent of enrollment, but 16 percent of expenditures. In fact, the costliest 10 percent of beneficiaries accounted for almost 70 percent of total expenditures in Medicare in 2001 (MedPAC, 2004, p.70).

Medicare HI Enrollment Demographics
Selected Years

Year	Number in thousands	Percent Distribution by Age						Median Age in Years
		Total	65-69	70-74	75-79	80-84	85+	
1966	19,082	100.0	34.1	28.7	19.8	11.2	6.2	72.6
1970	20,361	100.0	33.3	27.2	20.3	12.0	7.2	73.0
1975	22,472	100.0	33.5	26.3	19.3	12.5	8.4	73.0
1980	25,104	100.0	33.1	26.3	18.8	12.2	9.6	73.0
1985	27,683	100.0	31.9	26.3	19.2	12.3	10.3	73.3
1990	30,464	100.0	31.4	25.7	19.5	12.7	10.7	73.5
1995	32,742	100.0	28.7	26.4	19.8	13.5	11.6	74.0
1999	33,519	100.0	26.8	25.5	21.3	14.0	12.4	74.6
2000	33,841	100.0	26.9	25.1	21.3	14.2	12.6	74.6
2001	34,039	100.0	26.8	24.8	21.1	14.5	12.7	74.7

Table 2.1. Medicare HI Enrollment Distribution by Age (From CMS Website).



Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2001.

Figure 2.5. Medicare Enrollment and Expenditures Based on Age. (From MedPAC, 2004, p.4).

c. Increase in Healthcare Expenditures

Another trend impacting the future of Medicare is the increase in national healthcare expenditures. Over the past few decades, national personal healthcare expenditures as a percentage of Gross Domestic Product have increased significantly. One reason for the growth in expenditures is the increased utilization of new and more expensive medical technologies. (Other factors include enhancements in health insurance coverage, increasing per capita income, medical price inflation which exceeds general inflation, and the aging of society (Holtz-Eakin, March 2003, p.3).)

Figure 2.6 illustrates the historical trend of personal healthcare expenditures as it relates to GDP from 1980 to 2003. Personal health spending was 7.7 percent of GDP in 1980, and increased to 12.8 percent in 2003. Over the same period of time, Medicare expenditures doubled as a percentage of GDP, from 1.3 percent in 1980 to 2.6 percent in 2003 (MedPAC, 2004, p.66).

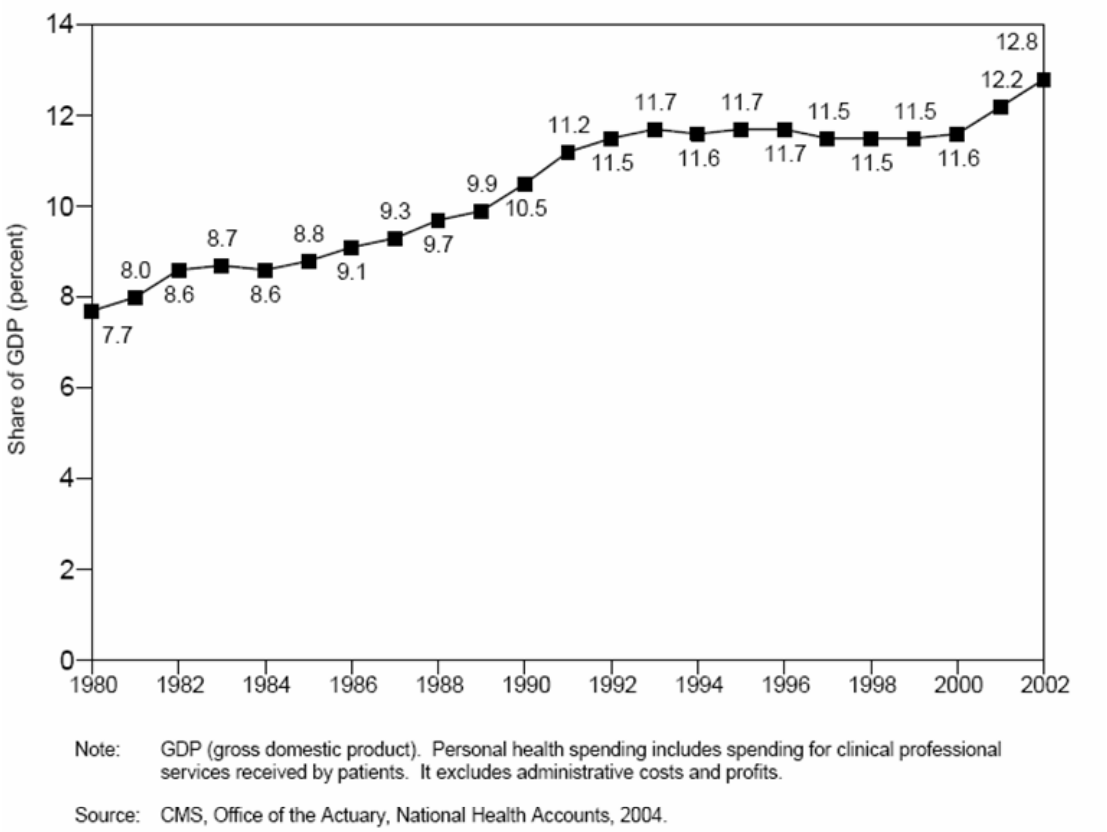


Figure 2.6. National Personal Healthcare Expenditures as a Percent of GDP. (From MedPAC, 2004, p.65).

To place the trend in another perspective, the cost of healthcare per person has also increased over the years, and this trend is not only seen in Medicare expenditures, but across the nation. National healthcare spending per person grew at an average annual rate of 4.5 percent between 1970 and 2002, or in 2002 dollars, it increased from $1,321 in 1970 to $5,366 in 2002 (Holtz-Eakin, March 2003, p.3). This rate of growth surpasses the growth in the nation's economy during the same period of time by 2.4 percent.

Combined, these three trends create a precarious future for Medicare's solvency and sustainability. The ultimate question is not whether the trust funds have

enough assets to finance the expenditures, but whether the government and the economy can afford the entitlements at the opportunity cost of financing other government programs.

D. REASONS FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

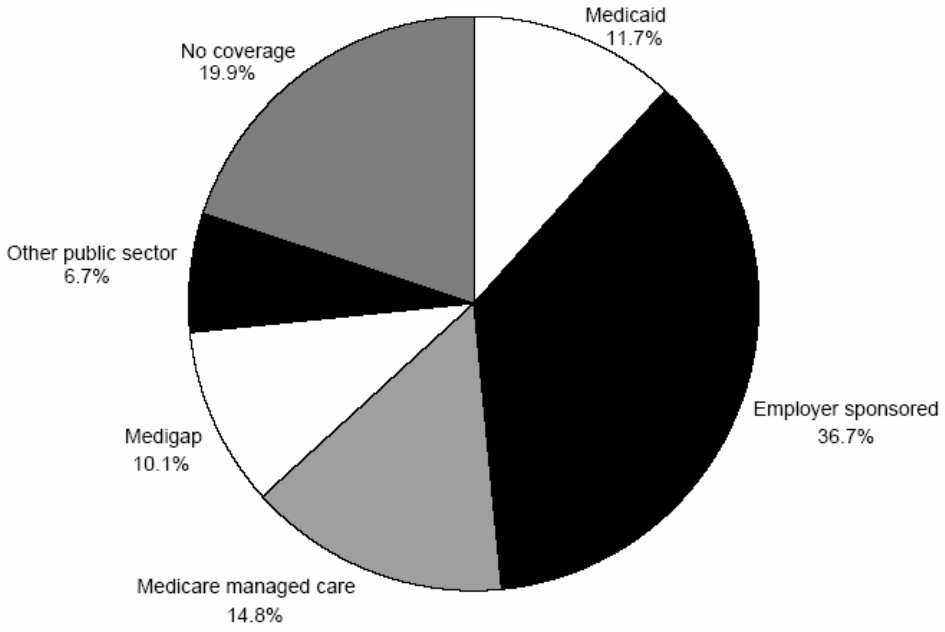
As mentioned in the preceding section, Medicare currently faces huge problems that impact its sustainability. Added to these challenges were concerns about gaps in the Medicare program that would leave beneficiaries vulnerable to huge out-of-pocket costs, such as the lack of outpatient prescription drug benefits. With these challenges in front of them, the 1st session of the 108th Congress began the 2003 legislative year with the goal to create a bill to modernize Medicare and add an outpatient prescription drug benefit.

1. Results of Excluding Outpatient Drug Coverage

When the Medicare legislation in 1965 excluded outpatient prescription drug coverage, it prompted the creation of other sources of coverage for beneficiaries. Among the options available were employer-sponsored plans for retired and current employees, privately purchased supplemental plans or Medigap, Medicare + Choice, and Medicaid. Having these options available to a majority of beneficiaries caused Congress to delay any amendments to the Medicare Program that included an outpatient prescription drug benefit.

Figure 2.7 shows the sources of prescription drug coverage among Medicare beneficiaries as of 2001. It indicates that 80 percent of beneficiaries had some source of coverage while almost 20 percent of beneficiaries had no coverage at all. Figure 2.8 shows the sources of payment

for prescription drugs among Medicare beneficiaries in 2001. Even though 80 percent of beneficiaries had prescription drug coverage, they still paid nearly 35 percent of the costs out of pocket. The next largest payment source was employer-sponsored coverage at almost 31 percent.



Note: Other public sector includes federal or state programs not included in the other categories. Analysis includes only beneficiaries living in the community. Totals may not sum to 100 due to rounding.

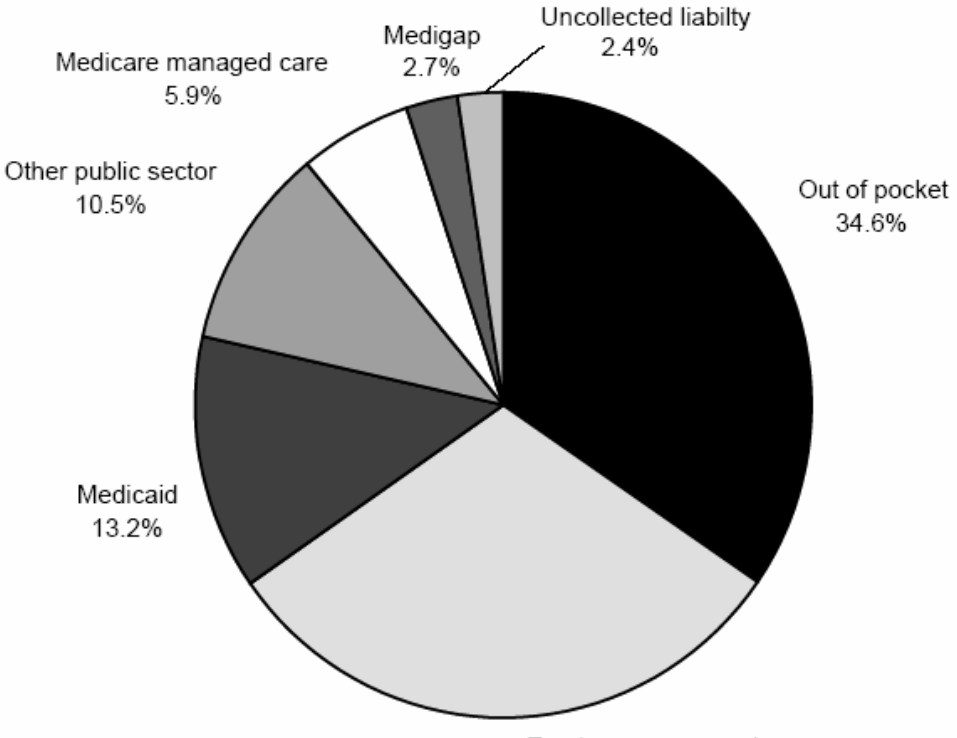
Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

Figure 2.7. Sources of Outpatient Prescription Drug Coverage Among Medicare Beneficiaries, 2001 (From MedPAC, 2004, p.157).

2. Amendments Include Physician-dispensed Drugs

Between the years of Medicare's expansion in 1972 and 2001, Congress added amendments to Medicare providing for payments to physicians who provide drugs to beneficiaries during office visits; Part B of Medicare would cover these drug expenditures. Most drugs were for treatment of diseases such as cancer and anemia related to renal disease. In 1992, costs for the physician-dispensed drugs

covered by Medicare were $700 million. In 2001, 454 drugs were included in Part B coverage, at an annual cost of $6.4 billion. Figure 2.9 shows Medicare spending for drugs covered under Part B, and annual growth rates. The large increase in costs for the physician-dispensed drugs covered by Medicare Part B caught the attention of several lawmakers. Additionally, the inspector general for the Department of Health and Human Services estimated that Medicare was paying two to ten times more than wholesale prices for the drugs being dispensed by physicians (Oliver, Lee, Lipton, 2004, p.292).

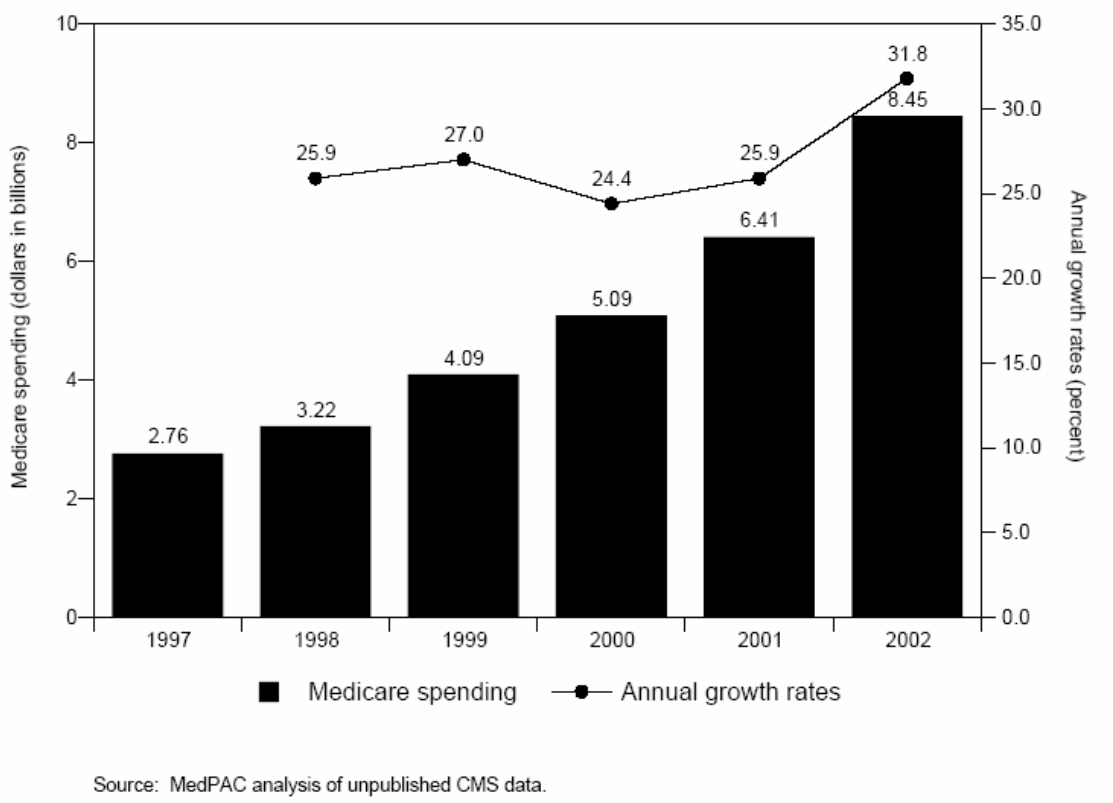


Note: Other public sector includes federal or state programs not included in the other categories. Analysis includes only beneficiaries living in the community.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001.

Figure 2.8. Sources of Payment for Prescription Drugs Among Medicare Beneficiaries, 2001 (From MedPAC, 2004, p.

158).



Source: MedPAC analysis of unpublished CMS data.

Figure 2.9. Medicare Spending and Annual Growth Rates for Part B Covered Drugs (From MedPAC, 2004, p.161).

3. National Prescription Drug Usage Trend

The reported reason not to include outpatient prescription drug benefits as part of the original 1965 Medicare legislation was due to the *unpredictable and potentially high costs related to prescription drugs*. At the time Medicare was enacted, prescription drug costs were 10 percent of national health spending (Oliver et al, 2004, p. 291). According to the Congressional Budget Office, in 2003, prescription drug costs were still only 10 percent of national health spending (Holtz-Eakin, March 2003, p. 3). Based on these figures, drug costs as a percentage of national health spending have not changed drastically over the long-term. However, total national healthcare expenditures have increased and, in the last ten years,

prescription drug spending has increased at a rate higher than overall healthcare spending. In 1980, national healthcare spending totaled $245.8 billion and prescription drug spending totaled $12.0 billion (4.9 percent). In 1990, total healthcare spending more than doubled to $696 billion while prescription drug spending more than tripled to $40.3 billion (5.8 percent). By 2000, total healthcare spending grew to $1,299.5 billion while spending for prescription drugs more than tripled again to $121.8 billion (9.4 percent) (CMS Website, August 2004). The growth in prescription drug spending was much steeper than national healthcare expenditures in the last 20 years. On a per capita basis, spending on prescription drugs grew at an average rate of nine percent per year between 1990 and 2002 while all other healthcare expenditures grew at an average annual rate of three percent. (Holtz-Eakin, March 2003, p.3).

Table 2.2 shows annual expenditures on prescription drugs in the U.S. from 1996 to 2001, the annual growth in prescription drug expenditures, and the annual growth in healthcare expenditures during the same period of time. The average annual growth rate in national prescription drug expenditures between 1996 and 2001 was 15.9 percent. The average annual growth rate in national healthcare expenditures, however, was only 6.5 percent in that same time period. The data above and in Table 2.2 indicate that prescription drug spending has increased rapidly in recent years, while staying steady at 10 percent of total national healthcare expenditures since Medicare's creation.

Year	Prescription drug expenditures (in billions)	Annual growth in prescription drug expenditures from previous year (percent)	Annual growth in health care expenditures from previous year (percent)
2001	$140.6	15.4	8.7
2000	121.8	17.3	6.9
1999	103.9	19.2	5.7
1998	87.2	15.1	5.4
1997	75.7	12.8	4.9
1996	67.2	10.5	5.0
Average annual growth from 1996 through 2001		15.9	6.5

Source: CMS, Office of the Actuary.

Table 2.2. National Expenditures for Prescription Drugs and Healthcare from 1996 to 2001 (From Walker, 2003, p.17).

E. DESIGNING A PRESCRIPTION DRUG BENEFIT

Adding a benefit to Medicare as large as outpatient prescription drug coverage requires the consideration of many factors. Benefit design impacts many things, and may cause unintended consequences if incentives are not compatible with the desired outcomes of the lawmakers. The benefit design may impact the drug industry by affecting demand and pricing of prescription drugs, and enrollment in the program is impacted by possibly attracting the people with the highest drug costs. These two factors will potentially impact the desire of private companies to administer the drug benefit. The design of the benefit may also affect how federal and state programs operate, such as Medicaid, as well as the other parts of Medicare, such as Part A. The choices of a design for a prescription drug benefit in Medicare may also affect other parts of the health insurance market.

1. Structure and Scope of the Drug Coverage

Important decisions in the design of the benefit are the scope and structure of the prescription drug benefit. How extensive to make the coverage and how widely available to make enrollment must be decided while trying to keep the benefit affordable and sustainable for the beneficiaries and the federal government. The scope and structure of the coverage have the greatest impact on the cost of the prescription drug benefit.

a. Structure

The choices that form the structure of the plan include the deductible amounts, the cost-sharing rates, the benefit caps, and the catastrophic stop-loss amounts (CBO, 2002, p.10). Figure 2.10 illustrates a notional structure for a prescription drug benefit, depicting the elements of structure described below.

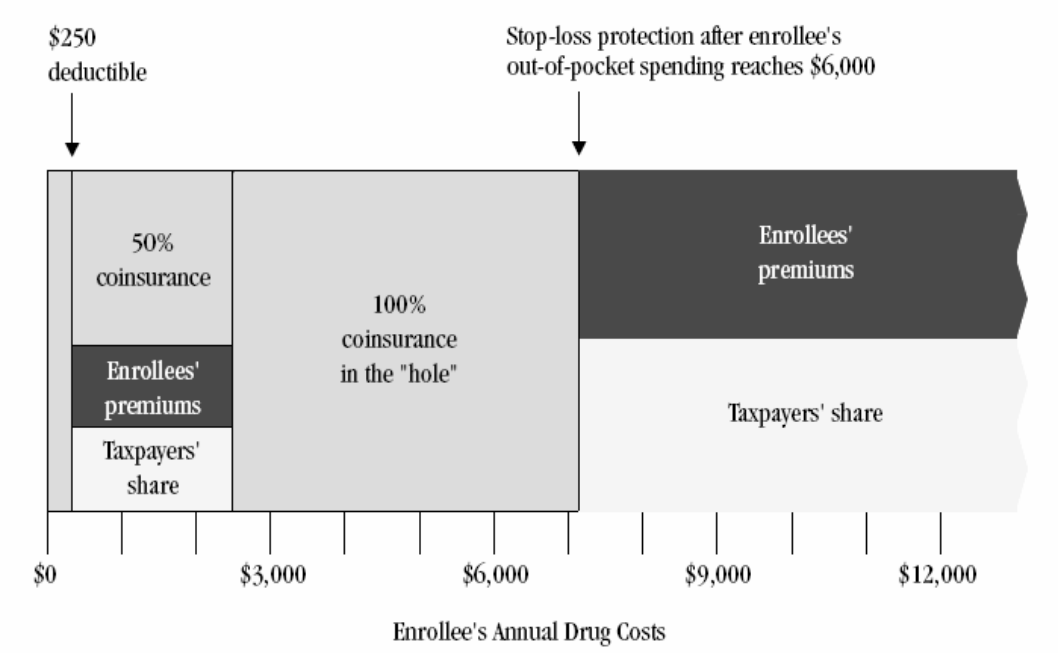


Figure 2.10. Hypothetical Structure of a Medicare Prescription Drug Benefit (From CBO, 2002, p.10).

(1) Deductibles. The deductible amount determines when coverage begins. If there were no deductible, coverage would begin immediately with the first dollar spent by the beneficiary. If the deductible were $250, it would begin with the 251st dollar spent.

(2) Cost-sharing. The cost-sharing rates determine how much of the cost of a prescription drug is paid by the enrolled beneficiary. If coinsurance is 50 percent of the cost, the portion of the cost not paid by the beneficiary is paid by the combination of SMI incomes (taxpayer dollars from the general fund or enrollee's premiums). Cost sharing in the above scenario begins at the 251st dollar spent on prescription drugs, and continues to the initial coverage limit.

(3) Benefit Cap. Benefit caps determine the total amount of coverage to be made available by the plan, beyond which the enrollee picks up the additional drug costs. If the initial coverage limit is set at $2,500, the enrollee must pay the full cost of all prescriptions beginning with the 2,501st dollar. In the above scenario, the benefit cap is equal to 50 percent of the difference between the initial coverage limit and the deductible paid by the beneficiary. So, the benefit cap is (.50) x ($2,500 - $2,250) = $1,125.

(4) Stop-loss. Catastrophic stop-loss determines the level of beneficiary out-of-pocket spending at which the benefit begins to pay all or most of the prescription drug costs. If the stop-loss is set at $6,000 of out-of-pocket costs, at $6,001, the cost is paid by the SMI trust fund.

(5) The doughnut hole. Between the benefit cap and the catastrophic stop-loss there is a gap in the coverage, also known as a 'doughnut hole'. In the above scenario, the benefit would have a gap in coverage between $1,125 and $6,000. The beneficiaries would have to pay all prescription drug expenses out-of-pocket between $1,125 and $6,000.

b. Scope

The scope of drug coverage will determine who is eligible for the benefit, how much coverage will be given to the beneficiaries, and, ultimately, the level of and structure of federal subsidies. Traditionally, Medicare has been a universal benefit based on age and/or disability. By this we mean that all beneficiaries are eligible for the same coverage regardless of annual income, assets, or enrollment in other insurance plans.

(1) Enrollment Eligibility. Design of the benefit for prescription drugs requires decisions about who the eligible beneficiaries will be and what criteria must be met. For example, would everyone be eligible who is enrolled in Part A and/or Part B? Will it only be available for the elderly? Will the criteria be based on income, or whether a beneficiary has drug coverage through another healthcare plan? The answers to these questions are essential to the design of the outpatient prescription drug benefit, and are an important factor in determining the cost.

(2) Voluntary Enrollment. Other decisions that affect enrollment are whether enrollment will be voluntary and if there will be restrictions on voluntary enrollment that will limit when beneficiaries may choose to enroll, or if they incur penalties for late enrollment or

dropping of the drug coverage. This could prevent "adverse selection" where those with higher-than-average expected costs have disproportionately higher enrollment in an insurance or drug plan. This could also lead insurers who administer plans to create a plan that discourages costly beneficiaries from enrolling through the use of marketing strategies, premium costs, or co-payment expenses.

(3) Level and Structure of Federal Subsidies. How much the federal government would contribute to the cost of drug coverage for beneficiaries of Medicare and how these subsidies would be structured are also important design decisions that have a large impact on the costs of the prescription drug benefit (CBO, 2002, p.11).

The higher the subsidy paid by the government, the greater the number of enrollees there will be, and, obviously, the higher the costs to the government. A penalty for late enrollment would provide an incentive to younger beneficiaries to enroll and reduce the impact of the adverse selection resulting from higher enrollment of older, higher-cost beneficiaries.

Providing additional subsidies for lower income beneficiaries would also affect enrollment numbers and costs to the federal government. The costs to the federal government can be limited by allowing only those beneficiaries whose incomes fall between certain levels to be eligible for the benefit. This saves costs, as studies have shown, due to the probability of lower income beneficiaries to require more, and more expensive prescription drugs. If subsidies were based on income level, it would also affect state and federal programs such as Medicaid. Perhaps most importantly, it would also be the first time that Medicare benefits were based on income.

For beneficiaries who also receive prescription drug benefits through other means, such as employer-based health plans, the willingness of the employer-based plans to continue to provide benefits to Medicare beneficiaries is likely to be impacted. If employers are aware of the eligibility of their employees for prescription drug coverage through Medicare, they may minimize the coverage in order to divert the costs of the more expensive employees from the health plans and towards Medicare. The impact, again, would be higher costs to the federal government for enrolling more of the 36 percent of beneficiaries covered by employer-based health plans. It may be in the interest of the federal government to provide subsidies to the employer-sponsored plans to maintain the level of benefits for Medicare-eligible beneficiaries, thereby keeping them enrolled in the private plans.

2. Administration of the Prescription Drug Benefit

The costs of the drug benefit would also be affected by the way the benefit is administered. Several models can be used as a framework for administering a drug benefit. The models most widely available for application to Medicare are the strategies being used by the private sector, that is, common employer-sponsored health plans, or the Federal Employees' Health Benefits Program (FEHBP).

Common private sector methods include the use of organizations called pharmacy benefit managers (PBMs). Pharmacy benefit managers offer comprehensive drug benefit packages to managed care organizations, employer groups, and other payers. They control costs by providing generic substitution programs and brand name products that are substantially discounted compared to those sold by retail

pharmacies. These companies negotiate prices by acting as intermediaries between pharmaceutical manufacturers and wholesalers, third-party payers, and pharmacies. PBMs also perform administrative functions such as claim processing and payment. How many PBMs would be used, and what regions they would serve are decisions of the designer of the prescription drug benefit. Other important decisions would be restrictions on the PBMs, how they would compete for enrollees, and how much insurance risk they would assume. Most Federal Employee Health Benefits (FEHB) providers use PBMs.

F. SUMMARY

This chapter discussed the creation and design of Medicare, fiscal challenges facing Medicare, reasons for adding a prescription drug benefit to Medicare, and factors to consider when designing a benefit such as outpatient prescription drug coverage. The next chapter discusses recent attempts to add an outpatient prescription drug benefit to Medicare, how differing views of the House and Senate, the Democrats and the Republicans, and special interest groups impact creation of this legislation, and introduce the proposal by President Bush in the budget for fiscal year 2004 to add a prescription drug benefit to Medicare.

III. MEDICARE REFORM AND OUTPATIENT DRUG BENEFITS

This chapter discusses recent attempts to add outpatient prescription drug benefits and introduce reforms to Medicare through legislation. It introduces various stakeholders, their views, and typical positions regarding the efforts to reform Medicare. Finally, it introduces the proposal in 2003 by President Bush to reform Medicare and provide a prescription drug benefit that laid the foundation Congress had to build upon.

A. BACKGROUND

As mentioned in the previous chapter, the Medicare program was created through a compromise between the King-Anderson bill supported by the Democratic party and Johnson Administration, and the Republican-supported Byrnes bill. The compromise produced a dual approach to health care insurance, Medicare, Part A, based on the Democratic proposal for hospital insurance, and Part B, based on the Republican proposal for physician services and outpatient drug coverage. During the compromise, the outpatient prescription drug benefits were removed. In lieu of outpatient prescription drugs being covered by Medicare, beneficiaries were offered coverage through a variety of supplemental plans ranging from employer-sponsored plans to Medicaid.

B. STAKEHOLDER INTRODUCTION

This section introduces stakeholders associated with legislation to create Medicare outpatient prescription drug benefits, and the traits that typify them. Stakeholders in the struggle for prescription drug benefits are numerous and varied. It is possible for an individual or group to

belong to more than one stakeholder classification. Summarizing the traits of each of the groups is difficult and necessarily inexact. That said, the stakeholders discussed here can be categorized into the following: the Administration, Congress, the political parties, and special interest groups.

1. The Administration

Members of the Administration with a stake in Medicare legislation include the President, his cabinet, and his political appointees. The views of the Administration change with the political party in control of the executive branch, as well as the individual elected president.

a. Boards of Trustees for Medicare Trust Funds

When Medicare was enacted in 1965, a separate Trust Fund with a separate Board of Trustees was created for both the Hospital Insurance and for the Supplemental Medical Insurance programs.

(1) Membership. Of the seven members designated to be trustees for the two Boards, three of them are members of the President's cabinet. The three cabinet members are the Secretary of the Treasury, Secretary of Labor, and Secretary of Health and Human Services (HHS). Also members are the presidential nominees (confirmed by the Senate), the Commissioner of Social Security, and the Administrator of the Centers for Medicare and Medicaid Services (CMS). The last two trustees are called public trustees. These individuals are also nominated by the President and confirmed by the Senate, but they cannot both be from the same political party, and they have four-year terms of service.

(2) Responsibilities. The Board of Trustees is responsible for holding the trust funds, providing

annual reports to Congress each year on the current status and future estimates of the health of the trust funds, reviewing the policies followed to manage the trust funds and recommending any necessary changes, and reporting to Congress immediately if the amount in either trust fund is too small to finance current obligations (http: //www.ssa.gov/history/reports/trustees/historypt.html, August, 2004).

b. Office of Management and Budget (OMB)

The Office of Management and Budget assists the President by overseeing the preparation and administration of the federal budget. It helps formulate the President's spending plans and supervises budget implementation within the federal agencies. OMB also coordinates with the federal agencies to ensure reports, rules, testimony, and proposed legislation are consistent with the President's Budget and with Administration policies (http://www.whitehouse.gov /omb/organization/role.html, August, 2004).

2. Congress

This stakeholder category includes members of the House of Representatives, the Senate, particularly members of committees who hold a stake in the creation of relevant legislation, and the agencies that support Congress in the legislative process. Party majorities in Congress, committee chairmen, and ranking members change. The amount of control one chamber has compared to the other also varies, depending upon the issue and other variables. Democratic and Republican members of Congress are influenced by the President and his Administration, as well as significant political events such as reelection, and lobby groups.

a. Committees and Subcommittees

When efforts to reform and expand a program that has as large a government and fiscal footprint as Medicare are being considered, many committees and subcommittees in the House of Representatives and the Senate are involved in the drafting and approval of the necessary legislation.

(1) The House of Representatives. The committees in the House of Representatives that have jurisdiction over Medicare legislation are the House Budget Committee, the Committee on Energy and Commerce-Subcommittee on Health, and the House Ways and Means Committee—Subcommittee on Health.

(2) The Senate. In the Senate, the committees that have jurisdiction include the Senate Budget Committee, the Senate Committee on Finance—Subcommittee on Health Care, and the Senate Committee on Health, Education, Labor, and Pensions.

(3) Special and Joint Committees. There are also several special and joint committees that have a stake in a Medicare drug benefit. These committees are the Joint Economic Committee—Subcommittee on Health, the Joint Committee on Taxation, and the Senate Special Committee on Aging.

b. Supporting Agencies

Congress has many agencies that help them create and decide on legislation with economic and budget-related impacts. The Congressional Budget Office, Government Accountability Office, the Medicare Payment Advisory Committee (MedPAC), and the Congressional Research Service provide nonpartisan analyses, testimony, and reports that

assist Congress to make decisions impacting legislation and policy.

(1) Congressional Budget Office (CBO). CBO's mandate focuses mainly on economic and budget matters, and its products to Congress include baseline budget projections and economic forecasts, analyses of the President's Budgets, analyses of long-term budgetary pressures and options for policy changes, and cost estimates for bills (http://www.cbo.gov/Mission.cfm, August, 2004).

(2) Government Accountability Office (GAO). Formerly the General Accounting Office, and commonly called the investigative arm of Congress, GAO provides studies, testimony, and legal opinions to Congress on programs and expenditures of federal agencies. It studies how the federal government spends taxpayer dollars, and advises Congress and heads of executive agencies (such as Health and Human Services, HHS) about ways to make government more effective and responsive (http://www.gao.gov/about/what.html, August, 2004).

(3) Medicare Payment Advisory Commission (MedPAC). MedPAC is an independent federal body established to advise Congress on issues affecting the Medicare program. It was established with the Balanced Budget Act of 1997 in order to advise Congress on payments to private health plans participating in Medicare (Medicare + Choice) and providers in Medicare's traditional fee-for-service program. The MedPAC commissioners are appointed to three-year terms by the Comptroller General and serve part time. The commission meets frequently with staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health

care providers, and beneficiary advocates to discuss policy issues. It formulates its recommendations for Congress in two reports issued in March and June each year.

(4) Congressional Research Service (CRS). The CRS researches public policy exclusively and directly for members of Congress, its Committees, and staffs on a confidential basis. CRS provides Congress with analysis, research, and information to help contribute to the legislative process (Congressional Research Service [CRS], 2002, pp.4-5).

3. The Political Parties

Political ideology and party positions change over time, so making generalizations about either is problematic. Most importantly, politicians are individuals who reflect a wide range of opinions; thus, a particular elected official will not necessarily fit neatly into any single set of categories. The United States has, traditionally, maintained two main political parties, the Democratic and Republican parties. Generally speaking, Democrats advocate a more liberal position while Republicans support a more conservative platform (http://www.balancedpolitics.org, August, 2004).

a. Democrats

A classically liberal platform favors economic activism by the government that includes, among other things, protection of the environment and consumers. In social affairs, liberals are inclined to oppose government intervention. Modern liberalism has the same premise as the classic ideology, but differs in that it favors government action to end discrimination, reduce poverty, provide health care for all citizens, and allow an education for everyone. Modern liberalism also considers it the

responsibility of the government to limit extreme inequalities of income (http://www.socialstudieshelp.com, August, 2004). The Medicare Program has been a traditional theme of the Democratic party because it falls under the platform of providing health care for all retired and disabled people through a large government-controlled organization.

b. Republicans

A classic conservative favors a limited government role in the economy which includes low taxation and minimum regulation. Modern conservatism believes in free market capitalism. Although not completely opposed to the Medicare Program, the Republicans support private party administration of the program, and forms of competition that they believe foster lower health care costs.

4. Special Interest Groups

Special interest groups represent a range of points of view and concerns. They may be linked to political parties or they may be nonpartisan, profit-driven or nonprofit, privately funded, government funded, or funded by educational institutes. Invariably, interest groups attempt to influence policy through several methods, but mainly by supplying public officials with things they want. These things include credible information, public support, and financial support.

Information provided by interest groups may help a legislator take and support a position on an issue. On highly visible issues, an interest group can raise support from its members to help with public support for proposed legislation (http://www.socialstudieshelp.com, Aug, 2004). Interest groups help finance election campaigns through

political action committees or soft money donations, lobby Congress for their members' interests, and occasionally provide jobs to former government officials.

Interest groups often raise money through foundation grants, federal grants, membership dues, and private industry donations to help obtain their goals on Capitol Hill. Obviously, special interest groups are not necessarily objective, and their motives may be hidden, especially if their goal is to influence public policy. The tangled web of special interest groups identified in this chapter is comprised of those that have a stake of some kind in Medicare prescription drug legislation related to Medicare beneficiaries or retirees, the health insurance industry, pharmaceutical companies or research foundations.

a. Membership Groups

A large government program such as Medicare promotes the creation of interest groups through the memberships of senior citizens and beneficiaries. The beneficiaries have an incentive to use groups to help protect and organize expansions to their current benefits. Two special interest groups that claim representation for senior citizens and have been active in the Medicare prescription drug legislation include AARP, the Alliance for Retired Americans (ARA), and Families USA.

(1) AARP. AARP is a nonpartisan, nonprofit organization of 35 million Americans age 50 and older. Formerly known as American Association for Retired Persons, it shortened its name to simply the abbreviation "AARP" to better represent its non-retired members. The AARP mission statement reads: "AARP is dedicated to enhancing quality of life for all as we age. We lead positive social change and

deliver value to members through information, advocacy and service" (http://www.aarp.org/leadership/Articles/a2002-12-18-aarpmission.html, August, 2004). AARP has two affiliated groups under its organization, the AARP foundation and AARP Services, Inc (ASI).

The AARP foundation is a charity group with a mission to: "provide security, protection and empowerment for older persons in need" (http://www.aarp.org/foundation-about/Articles/a2002-12-03-background.html, August, 2004). It sponsors programs such as litigation support, Tax-Aide, the Senior Community Service Employment Program (SCSEP) and the Money Management Program.

ASI is a for-profit, wholly owned subsidiary of AARP. A wholly owned subsidiary is one whose stock is owned by the parent organization. ASI manages a range of products and services available to AARP members, provides marketing services to AARP and its member service providers, and manages the AARP website. ASI provides a range of insurance products, including supplemental Medicare, supplemental hospital, long-term care, automobile, homeowners, and life insurance. It also provides pharmacy services such as prescription drug and medical supply discount programs, eye-health services, and eyewear products (http://www.aarp.org/leadership-executives/Articles/a2003-01-27-sweeney.html, August, 2004).

(2) Alliance for Retired Americans. Established in May of 2001, the ARA "aims to influence government through action on retiree legislative and political issues at the federal, state and local levels" (http://www.retiredamericans.org/index.php?tg=articles&topics=1&new=0&newc=0, August, 2004). The ARA was created by the American Federation of Labor and Congress of Industrial

Organizations (AFL-CIO), a voluntary federation of 60 national and international labor unions. The ARA offers members health insurance coverage to supplement Medicare [http://www.araretireehealth.com, August, 2004]. These member services and benefits are offered through Union Plus® health insurance programs, offered by Union Privilege which was created by AFL-CIO in 1986.

(3) Families USA. This organization is a national nonprofit, non-partisan organization that has been a voice for health care consumers for over 20 years. Among its many functions it manages a network of organizations and individuals that works for the consumer perspective in national and state health policy debates, acts as a watchdog over government actions affecting health care, alerts consumers to changes, produces health policy reports that describe problems facing health care consumers, and conducts public information campaigns about the concerns of health care consumers (http://www.familiesusa.org/site/PageServer?pagename=AboutUs, August, 2004).

(4) Alliance for Health Reform. This is a nonpartisan, nonprofit group that "believes that all in the U.S. should have health coverage at a reasonable cost" (http://www.allhealth.org/mission.asp, August, 2004). The Alliance claims it does not lobby for particular legislation, but provides unbiased information for policy makers "so they can understand the roots of the nation's health care problems and the trade-offs posed by competing proposals for change" (http://www.allhealth.org/mission.asp, August, 2004). The chairman of the Alliance's board of directors is Senator Jay Rockefeller, a Republican from West Virginia. The vice chairman of the board is Senator Bill Frist, a Republican from Tennessee, and a heart and

lung transplant surgeon. Other members of their board include leaders from the fields of medicine, labor, consumer advocacy and public interest.

b. Health Care Industry Groups

The health care industry, mainly health insurers, are especially concerned about government regulations for the delivery of Medicare services by the private sector, as well as the formularies that will be used to decide their payment schedules. In the past, the health insurers have learned that government regulations can make providing health care coverage to seniors too complex, and ultimately not worth the effort. Groups that have been formed to look out for their interests include America's Health Insurance Plans (AHIP) and Pharmaceutical Care Management Association (PCMA).

(1) America's Health Insurance Plans. AHIP is "the national association representing nearly 1,300 member companies that provide health insurance coverage to more than 200 million Americans" (http://www.ahip.org/content/default.aspx?bc=31, August, 2004). Its member companies offer medical expense, long-term care, disability income, dental, supplemental, and stop-loss insurance to consumers, employers, and public purchasers. Their goal is "to provide a unified voice for the health care financing industry, to expand access to high quality, cost effective health care to all Americans, and to ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice" (http://www.ahip.org/content/default.aspx?bc=31, August, 2004).

(2) Pharmaceutical Care Management Association. PCMA represents Pharmaceutical Benefit

Managers (PBMs). This group is "dedicated to enhancing the proven tools and techniques that PBMs have pioneered in the marketplace and works to lower the cost of prescription drugs for more than 200 million Americans" (http://www pcmanet.org/about_pcma.asp, August, 2004). As introduced in the previous chapter, PBMs are being widely used by many private health plans to provide drug benefits and save the plans money. PBMs are one method considered by drafters of Medicare prescription drug benefits to be able to contain costs. Many Federal Employee Health Benefit plans use PBMs for this reason.

c. Pharmaceutical Groups

The pharmaceutical industry has learned from the same experiences as the health insurers. Their interest in the prescription drug legislation is based upon the impact of government regulations governing the process for introducing generic drugs and their ability to extend patents on their brand-name drugs. Another possible impact is allowing the purchase and importation of drugs from other countries where they are less expensive than the United States.

One group that the pharmaceutical companies formed to look after their interests is the Pharmaceutical Research and Manufacturers of America. There has also been controversy regarding the use of "front" groups by the pharmaceutical industry, two of which are the United Seniors Association (USA), and The Seniors Coalition (TSC).

(1) Pharmaceutical Research and Manufacturers of America (PhRMA). PhRMA represents leading pharmaceutical and biotechnology companies, which also devote efforts to research and development of new drugs.

PhRMA's mission is "to conduct effective advocacy for public policies that encourage discovery of important new medicines for patients by pharmaceutical/biotechnology research companies" (http://www.phrma.org/whoweare/, August, 2004). The Pharmaceutical Research and Manufacturers of America Foundation, a subsidiary of PhRMA, is a non-profit organization. It provides funding for research and for the education and training of scientists and physicians who have selected pharmacology, pharmaceutics, toxicology, informatics or health outcomes as a career choice.

(2) United Seniors Association (USA). This organization has been identified as a "front" for the pharmaceutical industry by AARP and Congressional "watch dog" Public Citizen. It claims to work "to expand investment and retirement freedom, health freedom, tax freedom, national security and economic freedom for American families, their children, grandchildren, and great grandchildren" and calls itself a nonprofit nonpartisan organization under section 501(c)(4) of the Internal Revenue Code. The disclaimer on its website says that "because USA lobbies on behalf of American Families, contributions are not tax deductible for tax purposes" (http://www.usanext.org, August, 2004).

(3) The Seniors Coalition (TSC). The Seniors Coalition is also a "non-profit, 501c(4), non-partisan, education and issue advocacy organization that represents the interests and concerns of America's senior citizens" (http://www.senior.org/bin/view.fpl/10142/article/327/cms_article/327.html, August, 2004). Their goal is to "protect the quality of life and economic well-being that older Americans have earned while supporting common sense

solutions to the challenges of the future" (http://www.senior.org, August, 2004).

d. Research Foundations

Research foundations can receive their financial support through various means, including government grants, foundation grants, private industry, or individual donations. The research groups that will be discussed here are frequently used for credible information regarding the Medicare program and the prescription drug benefit.

(1) Kaiser Family Foundation. The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation that focuses on major health care issues facing the country (http://www.kff.org/about/index.cfm, August, 2004). The foundation provides facts and analysis for policymakers, the media, the health care community, and the general public. The Kaiser foundation has conducted research and analysis on several Medicare policy issues, including the addition of a Medicare prescription drug benefit, and has produced fact sheets, resource books and reports for policy discussions.

(2) The Center on Budget and Policy Priorities. This organization conducts research and analysis on proposed budget and tax policies to ensure that the needs of low-income families and individuals are considered in public debates. It also examines the short- and long-term impacts of proposed policies on the health of the economy and on the soundness of the budgets (http://www.cbpp.org/info.html, August, 2004).

(3) The Urban Institute. The Urban Institute is a nonprofit nonpartisan policy research and educational organization that studies social, economic, and governance problems facing the nation. It provides information to

public and private decision makers to help address challenges, and strives to raise citizen understanding of the issues and tradeoffs in policy making. Funding for Urban Institute projects comes from government agencies, foundations, and private institutions. The Health Policy Center at the Urban Institute studies how the dynamics of the health care market affect health care financing, costs, and access (http://www.urban.org/content/About/Mission/mission_081701.htm, August, 2004).

(4) Health Strategies. Health Strategies is a strategic consulting firm for the health care technology industry, government agencies, and medical foundations. They "operate as a cross between a think tank and a top management consulting shop" and "provide access to highly specialized research that is tailored to the confidential strategic needs" of their diverse customer base (http://www.healthstrategies.net/about/index.html, August, 2004). According to its website, the firm provides strategic guidance on policy issues, but does not lobby Congress or the Administration, and firm members are not registered lobbyists.

C. ATTEMPTS TO CREATE PRESCRIPTION DRUG BENEFITS

Since Medicare was enacted in 1965, several attempts have been made by the President and Congress to add outpatient prescription drug coverage to the benefits. This section will summarize the major efforts at adding a drug benefit to Medicare prior to 2003. Table 3.1 summarizes the benefits of the major prescription drug legislation.

Proposal Name	Enroll-ment Type	Premium Per Month	De-ductible Per Year	Beneficiary Co-Insurance (Total Drug Spending)	Benefit Cap & Catastro-phic Cap	Low Income Assist-ance	Admin-istration of Benefit	Estimate of Drug Benefit Cost
Medicare Catastrophic Coverage Act of 1988	Drug Benefit Added to Part B	$4 added to Part B premiums for higher-income	$600	Beneficiary Pays 20% after initial $600 until CC reached	BC: None CC: Tied to general CC of Part B	Lower premiums for lower-income	Federal Medicare Program and Part B carriers	Not Available
Health Security Act of 1993	Drug Benefit Added to Part B	$11 added to Part B	$250	Beneficiary Pays 20% after $250, 0% after $3750 Total Spending	BC: None CC: $1000 out-of-pocket	No	Federal Medicare Program and Part B carriers	Not Available
Medicare Rx Drug Act of 2000 (H.R. 4680)	Voluntary Enrollment in New Medicare Part D	Determined by the HHS Secretary, approx $25	$250 in 2003, indexed each year	Beneficiary Pays: 50% $250-2100 100% $2100-6925 and 0% above $6925	BC: $925 Gap: $4825 CC: $6000 out-of-pocket	Subsidy for premium & deductible for <150% of poverty	Private Drug Plans	$142 Billion + over 10 years (2001-2010)
Medicare Prescription Drug Act of 2002 (H.R. 4954)	Voluntary Enrollment in New Medicare Part D	Determined by the HHS Secretary, approx $35	$250 in 2005, indexed each year	Beneficiary Pays: 20% $250-1000 50% $1000 - 2000 and 100% $2000-4900	BC: $1100 Gap: $3250 CC: $3800 out-of-pocket	Subsidy for premium & deductible for <175% of poverty	Private Plans contracted by Federal Medicare	$309 Billion + over 10 years (2003-2012)

Sources: Library of Congress, H.R. 4680 and H.R. 4954

Table 3.1. Medicare Prescription Drug Benefit Proposals, 1988-2002.

1. Task Force on Prescription Drugs, 1967

Since its creation, Part A of Medicare covered all in-hospital prescription drug use and Part B of Medicare covered any prescription drugs that were dispensed in physicians' offices.

In 1967, the Secretary of Health, Education, and Welfare (HEW) established the Task Force on Prescription Drugs to examine the issues involved with adding a prescription drug benefit to Medicare Part B. The task force considered five main issues, most of which were still valid in 2003 when policymakers succeeded in passing legislation to add a prescription drug benefit to Medicare. The issues they considered were: the prices of prescription drugs, the formularies for pricing the coverage, prescription drug utilization, design of the cost-share

with beneficiaries, and pharmacy reimbursement (Oliver, et al., p.294).

In its final report on 02 February 1969, the task force announced that elderly Americans needed a Medicare drug insurance program, and that providing such a benefit was possible economically. After the task force's report was submitted, Nixon's HEW Secretary, Robert Finch, formed a committee to review its recommendations. The committee agreed with the findings of the task force, and asked the Secretary to endorse the recommendation for a prescription drug benefit to President Nixon. However, Secretary Finch did not endorse the recommendation. Measures to provide coverage were proposed in Congress, but the only result was expansion of Medicare eligibility to include the disabled and those with end-stage renal disease in 1972 (Oliver et al., p.294).

The addition of these new beneficiaries to the Medicare program also added a large entitlement for Part B coverage of physician-administered drugs that were especially common among dialysis patients. After this expansion, more and more drugs were added to the list of approved drugs covered by Part B, including those used to treat cancer. The skyrocketing costs to the Medicare program of these drugs were one reason legislators revisited a Medicare prescription drug benefit.

2. The Medicare Catastrophic Coverage Act, 1988

The Medicare Catastrophic Coverage Act (MCCA) of 1988 was the first major legislation to change Medicare since the 1972 expansion. It was also one of the most controversial and short-lived changes to Medicare.

The initial proposal by Health and Human Services Secretary Otis Bowen was an effort to provide seniors with protection from catastrophic medical costs, and alleviate gaps in Medicare's hospital coverage while lowering seniors' out-of-pocket expenses on hospital and physician services. One boundary condition provided by President Ronald Reagan was that the legislation had to remain budget neutral. No additional financing would come from the general tax fund.

The Republicans in Congress created the initial legislation, and a prescription drug benefit was added by the Democrats. In fact, AARP offered their endorsement of the legislation only if it provided prescription drug coverage. On the other hand, the Reagan Administration threatened to veto the bill if the drug benefit was included in it, and the pharmaceutical manufacturers spent three million dollars on a campaign to overturn the prescription drug proposal. The threat of a veto diminished after the Iran-Contra scandal made it unappealing for the Reagan Administration to fight against an expansion of a highly visible social program. It was in 1989 that The Seniors Coalition was formed to fight to repeal the MCCA. As mentioned previously, this special interest group receives most of its funding from the pharmaceutical companies.

Of course, the fact that it included a prescription drug benefit was not the most significant problem with the MCCA; the most controversial part was that the new benefits would be financed by beneficiaries. Beneficiary financing was included to meet the budget neutral criterion set by the Reagan Administration. The financing proposed for these

added benefits marked a turning point in Medicare policy, and how lawmakers considered Medicare. The MCCA proposed an increase in seniors' premiums based on their incomes. In the end, the new benefits proposed by the MCCA were largely financed by middle- and upper-income beneficiaries.

Enacted in June of 1988, it was repealed 17 months later, due to controversy and opposition from senior citizens and lobby groups regarding its means-tested financing and lack of adequate long-term care.

3. The Health Security Act, 1993

This proposal by the Clinton Administration was an attempt at a complete overhaul of the American health care system, not only Medicare. The plan called for comprehensive health care for all Americans, and added prescription drug coverage in the proposed plan, as well as Medicare.

To address the costs of the new prescription drug benefit, the government, especially Medicare, would use its large purchase volume to negotiate discounts from the pharmaceutical companies. The other idea to contain the costs was to make the health plans compete for business to make them more efficient and responsive to beneficiaries' needs.

The government's purchasing power would incorporate rebate agreements signed by pharmaceutical companies for brand-name drugs for a discount of at least 17 percent off average retail prices. If the drug companies raised a drug price at a rate greater than inflation, the government would get an added rebate. Another effort to control prices required that only generic drugs, if they existed, to be authorized through the program unless there was a clinical

reason for brand-name use. The mandate on generic pharmaceutical use had been part of the regulations for Medicaid and Medicare's in-hospital and physician-dispensed drug program since 1973 when HEW Secretary Caspar Weinberger made it a requirement. The pharmaceutical industry opposed the Health Security Act due to its fears that a large government-controlled prescription drug benefit would result in overbearing regulations on industry practices and price controls, as occurred in the 1970s.

In the end, the Clinton administration was unable to capitalize on Democratic control of the House and Senate, and all proposals at national health care reform failed to pass through Congress. Although not entirely related to the prescription drug benefit, the failure was due to a lack of support from Republicans and special interest groups.

4. The Balanced Budget Act, 1997

Signed into law by President Clinton in August, 1997, the Balanced Budget Act of 1997 was intended to reduce the budget deficit. The Balanced Budget Act also made changes to Medicare. The current and future costs of the Medicare program were a growing concern of the administration and lawmakers. The changes made by the Balanced Budget Act were a significant impact on the 30-year-old program.

The Balanced Budget Act proposed cuts in Medicare spending by $115 billion over five years and $385 billion over ten years. The reason the cuts in Medicare spending were deemed possible was because of the amount that would be saved through the new policies created in the Balanced Budget Act, namely Medicare Part C, Medicare medical savings accounts, changes in payment policies and formulas for providers and health plans, efforts to crack down on

fraud and abuse by Medicare providers, and the formation of the National Bipartisan Commission on the Future of Medicare. All of these efforts were intended to save money in the Medicare program in the long-term.

a. Medicare + Choice

The newly created Medicare Part C, or Medicare + Choice managed care plan, encouraged beneficiaries to switch from the traditional fee-for-service (FFS) Medicare to health maintenance organizations (HMOs) or preferred provider organizations (PPOs). The government and beneficiaries would pay Medicare premiums to insurance plans to deliver Part A and Part B services. The plans also offered prescription drug benefits to beneficiaries, a very desirable benefit for seniors. At its peak in 1999, Part C enrolled 6.3 million beneficiaries, or about 16 percent. Enrollment in Part C began to decrease, and beneficiaries returned to FFS, when the number of available managed care plans began to drop and insurers raised co-pays and cut benefits. In 2003, the number of beneficiaries enrolled in private plans had dropped to 4.6 million, or 11 percent of beneficiaries. The managed care plans were not generating as much revenue because the government would only pay certain premium amounts, and the HMOs and PPOs were losing profits.

b. The National Bipartisan Commission on the Future of Medicare

The creation of the 17-member National Bipartisan Commission on the Future of Medicare was also a milestone in the Medicare program. The Commission's co-chairs were Senator John Breaux (D-La.) and Representative Bill Thomas (R-Cal.). It was tasked with studying the main issues of Medicare and providing recommendations for reform. When the

commission concluded its studies in March of 1999, its key findings were: to switch to a system of premium support, to raise the eligibility age from 65 to 67, to increase co-payments, and to add a prescription drug benefit. The drug coverage that the commission recommended, however, had many limitations and problematic financing, including little relief for lower-income beneficiaries who could not afford the larger premiums required to finance the benefit.

The recommendations of the commission did not receive the requisite 11 of 17 votes in order for the report to be binding on Congress. The addition of the prescription drug benefit was a last-ditch effort to gain one more vote, but the remaining six voters held their votes back due to an underlying failure to find a compromise among the beneficiaries, providers, and insurance plans.

The efforts to reduce fraud and the payment reforms that stemmed from the Balanced Budget Act, along with a prosperous economy that created budget surpluses between 1998 and 2001, gave the Medicare program a break from the pending doom of insolvency. However, the idea of filling Medicare's financial gaps and adding a prescription drug benefit, spurred the introduction of numerous bills for consideration by Congress. The next section discusses the Medicare reform bills that were significant, yet still failed to go the distance.

5. Medicare Rx 2000 Act

The Medicare Rx 2000 Act was introduced by National Bipartisan Commission co-chair Bill Thomas, and passed in the House of Representatives by a vote of 217-214 on June 28, 2000. The bill was largely supported by the Republican

side of the aisle. There were only five Democratic and one Independent vote in favor of the bill, and ten Republican and one Independent vote against the bill. The bill was sent to the Senate, but it died without consideration. Its Medicare prescription drug provisions included a deductible of $250, co-payment of 50 percent up to $2100 in total drug expenditures, and catastrophic stop-loss after participants' out-of-pocket drug costs exceeded $6,000 after which Medicare would cover 100 percent. Low-income subsidies would be available for beneficiaries with incomes lower than 150 percent of poverty, and additional help would be available for those whose incomes fell under 135 percent of poverty.

6. Senate and House Proposals, 2001

In 2001 there were six attempts at Medicare prescription drug legislation in both the House and the Senate. The six House bills did not move past the two subcommittees on Health. The six Senate bills did not move past the Senate Finance committee. After the Economic Growth and Tax Relief Reconciliation Act was enacted in mid-2001, and Vermont Senator Jeffords changed parties from Republican to Independent, the Democrats briefly held control of the Senate. The Democrats tried six different variations of Medicare prescription drug bills, but they all stalled in committee.

7. Medicare Modernization and Prescription Drug Act of 2002

The Senate and House of Representatives once again attempted to pass legislation for a Medicare prescription drug benefit in 2002. Three bills were introduced in the Senate, but they only made it as far as the Committee on Finance because the Senate had failed to pass a budget for

fiscal year 2003, and they could not exceed the $350 billion limit in the previous year's budget resolution. Nine bills were introduced in the House, and one passed the House on June 28th. The bill was another Republican-supported bill, sponsored by Representative Nancy Johnson (R-Tex.), and it passed with a vote of 221-208. There were only eight Democrats and one Independent voting in favor of the bill, and eight Republicans and one Independent opposed to the bill.

The bill proposed a voluntary enrollment in Medicare Part D with a $250 deductible. Cost-sharing would require the private prescription drug insurers to cover 80 percent of enrollees' drug costs from $251 to $1,000, then 50 percent between $1,001 and the initial coverage limit of $2,000. Enrollees would cover all costs between $2,001 and $4900, and Medicare would cover the entire cost once the beneficiary reached the $3,800 out-of-pocket limit. Premiums would be determined by the HHS, estimated at $35 per month, and subsidies would be available for beneficiaries with incomes below 175 percent of poverty.

D. FRAMEWORK TO MODERNIZE AND IMPROVE MEDICARE

The reform of Medicare to include outpatient prescription drug coverage was a high priority for the Bush administration in 2003. After dozens of attempts in Congress to pass legislation for drug coverage under Medicare over the previous years, President Bush provided a framework from which Congress could begin to draft legislation that met the administration's guidelines for approval.

The President committed $400 billion over ten years in his fiscal year 2004 budget to modernize and improve

Medicare. The framework called for a prescription drug benefit, a choice of health care plan for beneficiaries, a choice of doctor, hospital, or treatment location for beneficiaries, full coverage for disease prevention such as cancer, diabetes, and osteoporosis screenings, and protection from high out-of-pocket costs (Executive Office of the President of the United States, March, 2003). Seniors would be able to get immediate discounts with a drug discount card that would be available in 2004, and low-income beneficiaries would receive assistance with premiums and cost-sharing, as well as a $600 annual subsidy for drug coverage. There would be three basic options available to beneficiaries: traditional Medicare, enhanced Medicare, and Medicare advantage.

1. Traditional Medicare

The first option available to beneficiaries would include continued enrollment in the traditional Medicare system. These beneficiaries would receive a discount drug card to save them up to 25 percent on the costs of prescription drugs and protection from high out-of-pocket costs. These added benefits would not increase their current premiums.

2. Enhanced Medicare

This option would give seniors health care choices through multiple health care plans. The plans would offer prescription drug benefits, full coverage of preventive benefits, protection against high out-of-pocket drug spending, and cost sharing that would not penalize beneficiaries who need access to more expensive medical care. Those enrolled in this option would be able to choose

any doctor or medical treatment facility they wanted for their care.

3. Medicare Advantage

This option is similar to Medicare + Choice. Seniors would have the option of low-cost, high-coverage managed care plans. Costs of the Advantage plans would vary based on the coverage selected by the beneficiary. Some plans would require no premium payments while others may have extra benefits that require additional premiums. Beneficiaries could opt out of drug coverage through these plans if they already have coverage through another source. These plans would also offer subsidies for low-income seniors.

E. SUMMARY

This chapter introduced the various stakeholders of the Medicare prescription drug legislation, their points of view and general positions on such legislation. It also discussed attempts to add outpatient prescription drug benefits to Medicare between 1967 and 2003. Finally, it introduced President Bush's Medicare reform proposal submitted to Congress in 2003.

The next chapter is dedicated to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. It discusses the various bills introduced in the House and the Senate, compares the bills that passed each chamber and discusses the major differences between the House and Senate versions. It also compares the Senate and House versions as it relates to the views of each political party. Next the chapter introduces the major issues negotiated between the two bills, how testimony from various stakeholders impacted negotiations, and how a

compromise was reached. Finally, the Medicare prescription drug legislation was the subject of controversy, and the issues that arose are introduced in the chapter.

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IV. MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

A. INTRODUCTION

The focus of this chapter is the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law (Public Law 108-173) by President George W. Bush on December 8, 2003. It will discuss the bills introduced in the House and the Senate in 2003, report the process that the bills followed in each chamber, and compare them. Next to be introduced are the major issues that were negotiated between the two bills and how testimony from various stakeholders impacted negotiations. Then the results of the compromises that were finally reached will be reported, followed by some of the controversy surrounding the bill. A chronology of the major events associated with the Medicare legislation is available in the Appendix.

B. BEGINNING OF LEGISLATION IN 2003

On January 28th, in his State of the Union address, President Bush announced that he wanted Congress to modernize Medicare and create a prescription drug benefit for its beneficiaries. On February 3rd he sent Congress his budget proposal for fiscal year 2004, requesting $400 billion over ten years for Medicare modernization including protection against catastrophic costs, better private options for all beneficiaries, and prescription drug coverage. The president's proposed budget for Medicare modernization is shown in Table 4.1.

Medicare Modernization
(In billions of dollars)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004–2008	2004–2013
Medicare Modernization.....	6	10	33	38	43	46	49	53	58	64	130	400

Table 4.1. President's FY04 Budget Proposal for Medicare Modernization (From OMB, 2003, p. 123).

1. Political Outlook in 2003

Although Congress had been unable to pass legislation for a Medicare drug benefit in recent years, the optimism for accomplishing this in 2003 was high. There were several reasons this legislative year could be different. The first was that Republicans had majorities in both the House and the Senate after the 2002 elections, and they also controlled the White House. The second reason was that the 2004 election year was around the corner, and the visibility of the Medicare legislation would likely earn the 2004 candidates votes, if Congress was successful on this issue. The third reason the outlook was good for a drug benefit in 2003 was that many lawmakers were aware that the federal deficit was growing, and a $400 billion offer to create the benefit may not be available again in the near future. All of these reasons made compromise possible by lawmakers who would otherwise be unwilling to yield their long-held ideals of what kind of coverage the legislation should or should not provide to seniors, and how it should be administered.

2. Reaction of Congress

On March 4th, President Bush provided the framework for Medicare introduced in the previous chapter. However, the framework did not satisfy most lawmakers. Many in Congress felt that the President's goals of major reform while

creating a drug benefit were too lofty. Many were of the opinion that the best possible outcome would be a prescription drug benefit for the lower income Medicare beneficiaries. Each party in the House and the Senate had concerns that would end up as major sticking points for compromise during committee conferences later in the year.

a. Democratic Concerns

While many stakeholders conceded that a drug benefit for low-income seniors would be a step in the right direction, most Democrats were opposed to this line of thinking. The main problem was that Democrats supported a drug benefit that would be available for ALL beneficiaries. They felt that basing the benefit on incomes went against the premise of Medicare. Means-testing was a tool that Medicaid used to ensure that low-income Americans were given basic health care. Medicare, on the other hand, was for all Americans aged 65 and older, as well as some under age 65 who were disabled, regardless of income. Many were also afraid that targeted benefits to the poor might alienate the middle-class and more affluent voters who continued to finance the system thru their payroll taxes. The outcome could be similar to what happened with the MCCA of 1988. Senator Edward Kennedy (D-Mass.) opined that some states would also oppose a Medicare benefit that would subsidize the low-income because they already had similar benefits available to the poor (Adams, 2003, p.999).

Another concern of the Democrats was that the drug coverage proposed by the administration for seniors who wanted to remain in traditional fee-for-service Medicare would not be adequate. They would be forced to seek a plan with a more robust drug benefit which may not

be advantageous to them in the long-run, due to availability in their market areas. Most Democrats were not completely opposed to privately managed plans, but thought beneficiaries should have adequate drug coverage in any plan they chose. Of course, they also admitted that a plan such as the one they favored could cost $500 billion more than the $400 billion that was proposed by the Republicans.

b. Republican Concerns

The House Republicans had been especially successful at passing bills for Medicare outpatient drugs in 2000 and 2002, although they never made it through the more closely divided Senate (Carey, 2004, p.238). They were certain that this year they could reach a consensus in the House once again, and knew that another failure in the Senate would reflect poorly on the leadership in both chambers, and the White House.

The basic desire of Republicans was to use private health care managers for Medicare and the prescription drug benefit on the theory that they would be cost efficient because of competition; however, even the most active Republicans in the House and the Senate agreed with the Democrats who believed adequate coverage also had to be available in a non-privately managed plan. Senate Majority Leader, Bill Frist (R-Tenn.), the Senate's only physician and long-time advocate of a Medicare prescription drug benefit, and Senate Finance Committee Chairman Charles Grassley (R-Iowa), who sponsored many bills aimed at low-income beneficiaries, were two such members. Frist and Grassley both argued against recreating a situation that happened to many seniors enrolled in Medicare + Choice. Seniors, especially those in rural areas, were forced out

of privately run Medicare + Choice plans when private insurers left Medicare due to low government reimbursements and excessive costs that dipped into their profits (Carey, 2003, p.563). The government was forced to provide subsidies to many private plans in order to entice them to continue to offer benefits to Medicare beneficiaries. Most plans dropped some of the very benefits, such as prescription drug coverage, that drew seniors to the plans in the first place.

Fiscal conservatives wanted to include reform measures that would defray the costs of added drug benefits. Other Republicans supported the idea of "targeted relief" (Carey, 2003, p.563) for seniors without prescription drug coverage who could not afford their drugs. They felt that a universal drug benefit would not be able to fit within the $400 billion bottom line. This is what the Democrats felt undermined the universal nature of the Medicare program. Many stakeholders, such as Families USA, thought that if everything else failed, the common ground could be a drug benefit for low-income seniors (Adams, 2003, p.999).

c. Bipartisan Issues

Both parties were concerned about three universal issues pertaining to Medicare and the drug benefit. First was the growing costs of the Medicare program even without the addition of a prescription drug benefit, the second was the pervasive "doughnut hole" in coverage characteristic of most current proposals, and third was the possibility of "employer crowd-out" (Carey, 2003, pp.563, 1358).

In 2003, the Office of Management and Budget estimated that Medicare spending in the traditional program

would rise from $230.9 billion in 2002 to $349.4 billion by fiscal year 2008, a 51 percent increase. The forecast for total federal expenditures during the same period of time was only a 35 percent overall increase. This meant that even without the prescription drug benefit, Medicare spending was growing at a rate exceeding all other federal spending, and would take an increased share of the total federal budget and account for a larger percentage of the annual GDP. The majority of this increase was due to the influence of the retirement of the baby boomers.

The two House-passed bills and most proposals had gaps in coverage embedded in the drug benefit. Many lawmakers opposed large out-of-pocket costs for seniors, but others saw it as a necessity if benefits were universal, not targeted to low-income beneficiaries. The questions in 2003 were how large the gaps would be. Would beneficiaries have to pay monthly premiums even though they were in the middle of a coverage gap? And, what would the maximum out-of-pocket costs be to beneficiaries?

The issue of employer crowd-out is more difficult to estimate. It is thought that it would be more likely as more beneficiaries were included in the Medicare drug coverage. Employers facing financial difficulties may decide to cut costs by abandoning drug coverage for their retirees, thereby making the costs of administering a drug benefit even more expensive for the federal government. Policymakers could try to add incentives for employers to maintain coverage, perhaps by giving companies a subsidy to help them continue to provide the benefit. But the ongoing economic slump and lower corporate earnings could prompt companies to curtail or drop retiree health care coverage

if they knew that those retirees were eligible for it elsewhere (Carey, 2003, pp.563, 1358).

As the 108th Congress began, Republicans and Democrats sorted through their respective positions. Lawmakers on both sides agreed on some issues and differed on others. Some in both parties viewed the overhaul efforts as a first step toward broader changes. Democrats saw it as a first step toward expanded benefits. Republicans saw it as a first step toward additional privatization. Both sides saw the "first-step" argument as justification for the compromises they were willing to make in order to see the benefit through the House and Senate (Carey, 2003, p.1358).

C. THE CONGRESSIONAL BUDGET RESOLUTION

As had many presidential budgets before it, the 2004 budget request by President Bush put money on the table for a Medicare prescription drug benefit. The 2001 Clinton budget had a proposal of $100 billion, the 2002 Bush budget proposed an amount of $153 billion, and the 2003 budget had an amount of $190 billion, all for the purpose of adding a prescription drug benefit to Medicare. The request by the President for $400 billion to Congress for this purpose was the largest amount proposed to date, and marked the beginning of the process for passage of legislation to provide the new benefit.

1. The House and Senate Budget Committees

After receiving the President's budget request, the two Budget Committees began receiving testimony from various cabinet members and expert witnesses on the fiscal year 2004 budget in their respective chambers. The Director of the Office of Management and Budget and the Secretary of

the Health and Human Services both provided testimony regarding the Medicare prescription drug benefit.

a. Senate Actions

On March 12th the Senate Budget Committee began to consider and mark up *The Concurrent Resolution on the Budget for FY 2004*, S.Con.Res. 23. On March 26th the Senate adopted its version of the budget resolution, by a vote of 56-44. The resolution established a reserve fund of up to $400 billion for FY 2004 through 2013 for legislation that would reform Medicare and improve the access of beneficiaries to prescription drugs or promote geographic equity payments.

b. House Actions

On March 12th the House Budget Committee began mark up and consideration of *The Concurrent Resolution on the Budget for FY 2004*, H.Con.Res 95. On March 21st the House agreed to the resolution by a vote of 215-212, a very tight and partisan vote, with the majority of Republicans voting for the resolution and the majority of Democrats voting against it. The House version of the budget resolution included a reserve amount of $7.5 billion for FY 2004 and a total of $400 billion in new budget authority and outlays for FY 2004 through 2013 for legislation that provided a prescription drug benefit and modernized Medicare.

2. The Budget Conference Agreement

After receiving the House version of the budget resolution, the Senate agreed to meet in conference with the House to resolve their differences. The conferees met between the 1st and 10th of April, and reported a conference agreement, H.Con.Res 95, to each chamber. The conference agreement contained language regarding the $400 billion

allocation for new Medicare legislation. In both the House and Senate versions of the budget resolution, the $400 billion was to be held in reserve. The funds would be available once Congress adopted a joint resolution or a conference report "that provides a prescription drug benefit and modernizes Medicare, and provides adjustments to the Medicare program on a fee-for-service, capitated, or other basis" (House of Representatives, 2003, H.Con.Res.95, pp. 52-54). Following such action, the Chairmen of the Committees on Budget could allocate for the purpose of Medicare reform, an amount "not to exceed $7 billion in new budget authority in 2004, and $400 billion in new budget authority for the period of 2004 through 2013" (House, 2003, H.Con.Res.95, pp. 52-54).

The House passed the conference agreement by another tight, partisan vote of 216-211. In the Senate, the vote was even closer. The Senate agreed to H.Con.Res 95 by a vote of 51-50. Vice President Dick Cheney had to break the tie. Although the Republicans held a majority in the Senate by a margin of 51 Republicans to 48 Democrats with 1 Independent, the vote was 50-50. Senator Zell Miller (D-Ga.) crossed party lines to vote for the agreement. Senators Lincoln Chafee (R-RI.) and John McCain (R-Ariz.), along with Senator James Jeffords (I-Vt.), voted against the resolution.

D. DEVELOPING THE PRESCRIPTION DRUG BILL

After it was agreed by both chambers in the budget resolution to allocate funds for the purpose of providing a prescription drug benefit and Medicare reform, Congress was required to produce a bill that met the criteria in order to have the funds made available in the resolution. This

section will focus on the legislative process in both the House of Representatives and the Senate, including decisions of the committees that have jurisdiction in each chamber.

1. The House of Representatives

In the first session of the 108th Congress, the House Ways and Means committee was led by Bill Thomas (R-Cal.). Nancy Johnson (R-Conn.) was head of the subcommittee on Health. In the House Energy and Commerce committee, the other committee with jurisdiction over Medicare, the chairman was Billy Tauzin (R-La.). The subcommittee on Health was chaired by Michael Bilirakis (R-Fla.). Early in 2003, the two subcommittees were given four bills that had been introduced in the House early in 2003, all providing a prescription drug benefit under the Medicare program. Of those bills, three had Democrat sponsors and one had a Republican sponsor. One of these bills, H.R. 1199, was allowed introductory remarks by the House Ways and Means Committee (Subcommittee on Health) on March 12th. No consideration was given to any of the other bills, and H.R. 1199 died in subcommittee.

The Ways and Means Subcommittee on Health did not have any hearings or testimony specifically focused on Medicare prescription drugs in 2003. It did hear testimony regarding payment and contracting reform, cost-sharing, and supplemental insurance (Medigap), all of which were related to Medicare reforms that included the prescription drug benefit. Four hearings were held between February and May of 2003 in which various stakeholders were able to share their points of view on these issues. The Energy and Commerce Subcommittee on Health heard testimony on

"Designing a Twenty-first Century Medicare Prescription Drug Benefit" on April 8th. During this hearing, testimony was given by several expert witnesses. The witnesses included health policy experts from universities, the director of The Seniors Coalition, a representative from AARP, and other health professionals. The subcommittee took more testimony on April 9th, when the topic was "Strengthening and Improving Medicare." The witnesses testifying that day included Mr. Rich Foster, the Chief Actuary for the Centers for Medicare and Medicaid Services (CMS) and Dr. Robert Bereneson, the former Head of the Medicare + Choice Services under CMS (then called Health Care Financing Administration). Also testifying were several representatives from special interest groups, such as Aetna insurance, the National Committee to Preserve Social Security and Medicare (a membership group), the Healthcare Leadership Council (a healthcare industry advocate), and Marilyn Moon, of the Urban Institute.

After the testimony, five more bills were introduced in the House, two by Democrats, two by Republicans, and one sponsored by an Independent. One of these five bills was introduced on June 16th, and over the next three days the Energy and Commerce Committee held a full committee mark up of the bill. The bill was H.R. 2473, the Medicare Prescription Drug and Modernization Act of 2003. This bill was co-sponsored by Billy Tauzin (R-La.), the committee chairman, and Bill Thomas (R-Cal.), the primary sponsor and chairman of the Ways and Means Committee. The committee agreed to the bill by a vote of 29-20, and reported it to the House.

The bill went to full committee mark up in the Committee on Ways and Means on the 17th of June. The committee amended the bill, and agreed to it the same day by a vote of 25-15, then reported it to the House.

After the two committees reported the bills, H.R. 2473 was combined with four other Medicare reform bills. The last-minute additions were included in hopes of persuading some teetering Republicans and Democrats to support it. The bills added provisions to allow for the reimportation of drugs from Canada, thereby decreasing drug costs, limited the ability of pharmaceutical manufacturers to extend patents to speed up the approval process for generic drugs, added roughly $28 billion in funding for hospitals and providers in rural areas, and established two types of tax-free medical savings accounts to be used for unreimbursed medical expenses. The bill was renamed H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

H.R. 1 was reported to the full House for a vote on June 25th. While the bill was on the floor of the House the evening of June 26th, the Republicans extended the vote period in the early morning hours of the 27th, and took some controversial actions. The vote was scheduled for 15 minutes. When the time expired, the tally was 210-214, and Democrats began to shout for a close to the vote. Democrats were almost unanimously against the bill (only 9 voted for it, mainly due to the added provisions for rural areas). Some moderate conservatives voted against the bill for one of the same reasons the Democrats opposed it, they "feared the competition provisions in the bill could gut traditional Medicare" (Bettelheim, August 2003, p. 690).

Over the next 30 minutes, the chairmen of the two committees (Thomas and Tauzin) joined Majority Leader Tom DeLay and Majority Whip Roy Blunt for visits to about a dozen members of their party on the floor who had withheld their votes. These more conservative members argued the opposite of their moderate colleagues, that "the bill did not do enough to promote competition and would merely boost government spending by adding a drug benefit" (Bettelheim, August 2003, p. 690).

The deciding 'yes' vote was cast by Jo Ann Emerson (R-Mo.). The price to switch her vote on H.R. 1 was the promise that the bill she sponsored would be granted a floor vote. Her bill would allow the importation of drugs from Food and Drug Administration-approved facilities in 25 industrial countries, not just Canada, a measure that could help lower drug prices for all Americans as well as the government (Allen, Graham-Silverman, 2003, p. 1614). Another rebellious Republican, and Emerson's co-sponsor of the drug importation bill, Gil Gutknecht (R-Minn.) said afterwards: "I probably could have gotten new highways, bridges, and probably some troop deployments, but I told them no" (Allen, Graham-Silverman, 2003, p. 1614). The Republican-sponsored bill passed the House by a vote of 216-215, with 19 GOP members voting against it.

2. Senate

In the Senate, the Committee on Finance had jurisdiction over Medicare legislation. Two bills were introduced in the Senate. On January 7th a bill sponsored by Senator Tom Daschle (D-SD.) was introduced and referred to the Committee on Finance where it subsequently died. The committee held hearings on the 3rd of April regarding

"Purchasing Health Care Services in a Competitive Environment." Testimony was given by an advisor for Employee and Family Policy at the federal Office of Personnel Management, the Deputy Secretary of Defense for Health Plan Administration, and two representatives from private health insurance groups. On June 6th, the committee held another session on "Strengthening and Improving the Medicare Program." Testimony was heard from Thomas Scully, Administrator of the Centers for Medicare and Medicaid Services. Other witnesses included an independent consultant and Marilyn Moon from the Health Policy Center at the Urban Institute.

Five days later, on June 11th, a bill co-sponsored by Finance Committee chairman Bill Frist (R-Tenn.) and Max Baucus (D-Mont.) was introduced. The following day, a committee hearing to consider this bipartisan bill (S. 1) was held. The bill was approved by the Finance Committee by a 16-5 vote that same day. This was a significant achievement for the Committee on Finance, as it marked the first time in five years that a Medicare reform bill would go to the Senate floor for debate.

Debate on the Senate floor for S. 1 commenced on June 18th. Over 100 amendments were submitted for addition to the bill, and 58 amendments were agreed to. The addition of amendments important to both parties continued to make the bill more bipartisan than the more conservative version in the House. S. 1, the Prescription Drug and Medicare Improvement Act of 2003, passed the Senate by a vote of 76-21. After H.R. 1 was received by the Senate, they amended the entire bill with the language of S.1, and returned H.R. 1 to the House. The House agreed to disagree with the

Senate version of the bill, and arranged a conference with the Senate to resolve the differences.

E. COMPARISON OF THE SENATE AND HOUSE BILLS

The Senate and House Medicare bills had the same basic structure for the prescription drug benefit, but the devil was in the details. This section describes the major prescription drug provisions in each bill, and discusses the areas where compromise was required when the bills went to conference between the two chambers. Table 4.2 shows a comparison of the two bills as passed by the House and the Senate, and the final conference agreement that became Public Law 108-173.

Proposal Name	Enroll-ment Type	Premium Per Month	De-ductible Per Year	Beneficiary Co-Insurance (Total Drug Spending)	Benefit Cap & Catastro-phic Cap	Low Income Assist-ance	Admin-istration of Benefit	Estimate of Drug Benefit Cost
H.R. 1: Medicare Prescription Drug and Modernization Act of 2003	Voluntary in New Part D Part C - Medicare Advantage Part E – Enhanced	$35.50 for Part D standard coverage in 2006	$250 in 2006, indexed each year	Beneficiary pays: 20% $250-2000 100% $2000-4850 and 0% above	BC: $1400 Coverage Gap: $2850 CC: $3500 out-of-pocket, indexed	Subsidy for pre-mium & deduct-ible for < 150% poverty	Part D by New 'Medicare Benefits Admin-istration' or Private Insurers thru Part C or E	$415 Billion over 10 yrs (2004-2013) (CBO Est.)
S. 1: Medicare Prescription Drug and Improvement Act of 2003	Voluntary in New Part D or Part C Medicare Advantage	$34 for Part D standard coverage in 2006	$275 in 2006, indexed each year	Beneficiary pays: 50% $275-$4500 100% $4500-$5675 and 10% above $5675	BC: $2250 Coverage Gap: $1175 CC: $3700 out-of-pocket, indexed	Subsidy for premium & deduct-ible for < 160% of poverty	Part D by New 'Center for Medicare Choices' in Dept. HHS or Part C	$422 Billion over 10 yrs (2004-2013) (CBO Est.)
Public Law 108-173: Medicare Prescription Drug, Improvement, and Modernization Act of 2003	Voluntary in New Part D or Part C Medicare Advantage Private Drug Plan (PDP)	$35 for Part D standard coverage in 2006	$250 in 2006, indexed each year	Beneficiary pays: 25% $250-2250 100% $2250-5100 & about 5% co-pay after $5100	BC: $1500 Coverage Gap: $2850 CC: $3600 out-of-pocket, indexed	Subsidy for premium & deduct-ible for < 150% of poverty	Part D by private plans or Part C by private plans	$410 Billion over 10 yrs (2004-2013) (CBO Est. dated Nov 20, 2004)

Sources: Library of Congress, H.R. 1 and S. 1

Table 4.2. Summary of the Provisions of the Medicare Legislation in 2003.

1. Provisions of the House Bill

a. Enrollment Eligibility

Similar to bills passed in the House in recent years, the House bill, H.R. 1, called for voluntary enrollment of Medicare beneficiaries in a new Part D of Medicare that would begin in 2006. Drug coverage would be provided through private plans offering drug-only coverage for those beneficiaries wanting to remain in traditional Medicare. They would also be able to receive drug coverage in Part C of Medicare, renamed "Medicare Advantage" plans. A new Part E, or Enhanced Fee-for-Service (EFFS) plan, would provide benefits for Medicare Parts A, B, and D all in one plan. In the meantime, a drug discount card would be available in 2004 along with subsidies for those without drug coverage.

b. Premiums, Deductibles, and Co-Insurance

The monthly premiums for H.R. 1 were estimated at $35.50, with an annual deductible of $250. After the initial $250, beneficiaries would pay a 20 percent co-insurance until the initial coverage limit of $2000 (or a benefit cap of $1400). Beneficiaries would then pay 100 percent of the costs until they reached the maximum out-of-pocket limit, or catastrophic cap, of $3500. The "doughnut hole" in this bill would be $2850. Higher income individuals, with adjusted gross incomes over $60,000 ($120,000 for couples) would have higher out-of-pocket limits. The thresholds for these wealthier beneficiaries would be determined by the HHS Secretary. All of these figures were based on a start date of 2006 for the benefit and indexed for subsequent years.

c. Low-income Provisions

Low-income subsidies would also be available for enrollees with incomes up to 135 percent of poverty level ($6000 individuals/$9000 couples). This would also include those eligible for Medicaid. These beneficiaries would not have an annual deductible, nor have to pay a premium for the standard drug coverage. The cost-sharing for those under the 135 percent level would be no more than $2 for generics and $5 for brand-name drugs up to the initial coverage limit. There would be no subsidies for the costs of drugs between the initial coverage limit and the out-of-pocket limit. Sliding-scale subsidies would be available for annual premiums for those enrollees with incomes between 135 percent and 150 percent of poverty. The Congressional Budget Office estimated that the prescription drug benefit of the H.R. 1 proposal would cost $415 billion over 10 years, all financed from the Treasury's general fund. They also estimated that 93 percent of eligible beneficiaries would participate in Part D.

2. Provisions of the Senate Bill

a. Enrollment Eligibility

The Senate bill, S. 1, also called for a voluntary outpatient drug benefit added through a new Part D to begin in 2006. Unless beneficiaries were already enrolled in Medicaid, they would be eligible for Part D. Drug coverage would be available through private plans offering drug-only coverage or through Part C, renamed "Medicare Advantage" plans which would offer an integrated package of Medicare benefits with drug coverage. A drug discount card would be available in 2004 as a low-income subsidy until the benefit went into effect.

b. Premiums, Deductibles, and Co-Insurance

The monthly premiums under S. 1 were estimated at $34. The annual deductible would be $275. After the initial $275, beneficiaries would pay a 50 percent co-insurance until total drug expenditures were $4,500, then 100 percent over $4,500 until they reached the maximum out-of-pocket limit, or catastrophic cap, of $3,700. The "doughnut hole" in this bill was $1,175. Then beneficiaries would pay 10 percent cost-sharing for all additional drugs. There would be no provision for higher catastrophic cap limits for higher income beneficiaries in the Senate version.

c. Low-income Provisions

Low-income subsidies in this bill are generally more complicated. The Senate bill would not allow beneficiaries eligible and enrolled for both Medicaid and Medicare to enroll in Medicare Part D plans (i.e., does not allow dual-eligible drug enrollment). One needs to know the definitions of QMB, SLMB, and QI to understand the subsidies granted to each group. A QMB is a Qualified Medicare Beneficiary whose income is below 100 percent of the poverty level and has limited assets. SLMB is a Specified Low-Income Beneficiary with an income between 100 percent and 120 percent of poverty. And a QI is a Qualified Individual whose income is between 120 percent and 130 percent of poverty. The Senate bill would cover all premiums and deductibles for those with incomes under 135 percent of poverty (including all QMBs, SLMBs, and QIs). QMBs would have no deductibles and pay a 2.5 percent coinsurance up to the initial coverage limit ($4500), then five percent to the out-of-pocket limit ($3700). SLMBs and QIs would have to pay a five percent coinsurance until

$4500, then ten percent until they met their out-of-pocket limit. Beneficiaries with incomes between 135 percent and 160 percent of poverty would receive premium subsidies on a sliding scale, pay a $50 deductible, and pay ten percent co-insurance up to $4500, then 20 percent up to the out-of-pocket limit. H.R. 1 provides more up-front benefit, but requires more out-of-pocket costs in the long-term than S.1, depending on the beneficiaries' annual drug costs.

The Congressional Budget Office estimated that the prescription drug benefit under the Senate bill would cost $422 billion over 10 years, all financed by the Treasury's general fund. CBO also estimated that 75 percent of beneficiaries would participate in the voluntary Part D of Medicare.

3. Other Major Differences

Besides the prescription drug provisions and low-income subsidies, there were other issues in H.R. 1 and S. 1 that affected the possibility of an agreement between the two chambers. These included the level of responsibility that the government would undertake, the degree of competition in private plans, and creation of medical savings accounts.

The Senate bill made a condition in which a government-run option for prescription drug and/or health care benefits would be available to beneficiaries if there were not more than two private plans in an area where a beneficiary needed care. This would provide beneficiaries with more than two options to find adequate coverage. The GOP-backed House bill did not include the government-run option. Senate Democrats warned that they would not support a bill from the House that lacked language providing a

government-sponsored fallback plan if the private health plans chose to withdraw from certain low-profit geographic regions. The President warned that this option could "discourage private entities from bearing the insurance risk for prescription drug coverage" (Adams, Carey, 2003, p. 1611).

Another issue related to private plans was whether traditional Medicare would have to compete against private plans on the basis of price. The Republican proviso was to have competition phased in over a five-year period. This was a favored plan of conservatives because they believed it would help keep program costs lower. The bipartisan S.1 would allow a more limited type of competition. When the benefit went into effect, private plans could bid against each other, but their payments would be limited by the rates for traditional Medicare. Beginning in 2009, private plans in select areas could bid directly against each other on price, but not directly with traditional Medicare (CQ Weekly, 2003, p. 1617). Forty-two Republicans in the House warned that they would not support a conference report that did not include the direct competition.

Lastly, when H.R. 1 was created by the combination of several bills, one of the bills added language to create two tax-preferred personal savings accounts for non-covered or unreimbursed medical expenses such as drugs or other care. The Senate bill did not create the same provision (CQ Weekly, 2003, p. 1617).

F. THE HOUSE-SENATE CONFERENCE

Prior to approval of the bills in each chamber, the White House sent a Statement of Administration Policy to the bills' sponsors and committee leadership. The

statements were largely pragmatic, but told the lawmakers that the "Administration look[ed] forward to working with Congress to improve" (OMB, June 2003) certain provisions. Most of the provisions needing improvement were unrelated to prescription drug benefits, with the exception of those mentioned previously in this chapter, namely the Senate's 'fallback' provisions and the House's income-related catastrophic limits for higher-income beneficiaries.

Considering the tight vote in the House for H.R. 1, the differences in the more bipartisan S. 1, and the fact that a conference agreement only needed 51 votes in the Senate, the GOP knew they could lose a dozen votes in the Senate and still pass the conference agreement.

There were 17 lawmakers selected to be conferees for the Medicare bill, the majority of whom were Republicans. The conferees selected by the House were mainly committee and subcommittee leadership (chairs and ranking members) as well as sponsors of bills on Medicare in 2003. Most have been mentioned previously in this thesis, and included, Rep. Bill Thomas (R-Cal.), Rep. Billy Tauzin (R-La.), Rep. Tom DeLay (R-Tex.), Rep. Michael Bilirakis (R-Fla.), Rep Nancy Johnson (R-Conn.), Rep. John Dingell (D-Mich.), Rep. Charles Rangel (D-NY.), and Rep Marion Berry (D-Ark.). Similarly, in the Senate, the conferees included the leadership and moderate Democrats. The Senate conferees included Sen. Bill Frist (R-Tenn.), Sen. Charles Grassley (R-Iowa), Sen. Don Nickles (R-Okla.), Sen Jon Kyl, (R-Ariz.), Sen. Orrin Hatch (R-Utah), Sen. Tom Daschle (D-SD.), Sen John Breaux (D-La.), Sen John Rockefeller (D-W.Va.), and Sen. Max Baucus (D-Mont.). The Conference

between the House and Senate on the two bills began on the 14th of July.

At the beginning of the conference, the Republicans kept the Democrat conferees out of the negotiations with the exception of two senators: Baucus and Breaux. No House Democrats were included, nor was the Senate majority leader, Daschle. In early November, talks between the conference members got bogged down on two main issues. An agreement could not be reached on the level of competition and whether to "give tens of billions of dollars in subsidies and tax credits to employers" (Carey, 2003, p. 2827) in order to provide an incentive for them to maintain coverage for retirees currently covered under their plans.

As proposed in each chamber, the gaps in coverage and high out-of-pocket costs would likely make seniors feel cheated, especially if they were required to pay monthly premiums and received no benefits while they were in the doughnut hole. Of course, in order to keep the cost of the legislation under $400 billion, it was necessary to have gaps in coverage.

The conference agreement represented a compilation of compromises on both the House and the Senate side. The final congressional step was gaining approval in both chambers. Many attempts were made to bring the bill to a vote in the House, but none were accepted until over four months after the conference committee began, on the 21st of November. Through the evening of the 21st into the morning of November 22nd, the House considered the conference report for H.R. 1 (H. Rept. 108-391), the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The report was agreed to by a vote of 220-215. It was agreed to

in the Senate by a vote of 54-44 on November 25th. The bill was sent to President Bush who, on December 8th, signed it into law as Public Law 108-173.

G. PROVISIONS OF THE DRUG BENEFIT IN FINAL BILL

The prescription drug benefit, as enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, takes full effect in January of 2006. Until that time, an interim Medicare-endorsed discount drug card and transitional assistance program would be available beginning in June 2004. The Drug Discount Card was estimated to provide a savings of 10 percent or more for enrolled Medicare beneficiaries.

Additional assistance of $600 per year would be provided to beneficiaries with incomes below 135 percent of poverty ($12,569 single/ $16,862 couple in 2004) if they did not have private or Medicaid drug coverage.

1. Enrollment Eligibility

Beneficiaries would have the option of enrolling in a Medicare drug plan beginning in November of 2005, and benefits would begin in January of 2006. Beneficiaries could remain in traditional fee-for-service Medicare and elect to enroll in new Medicare Part D, a separate private prescription drug plan (PDP). Beneficiaries could also enroll in an integrated Medicare Part C, renamed Medicare Advantage (MA). MA plans combine Parts A, B, and D, and are administered by a private insurance plan or health maintenance organizations (HMOs). If two or more plans, including at least one PDP, are not available in a beneficiary's local region, Medicare would contract with a "fallback" plan to serve beneficiaries (Kaiser Family Foundation [KFF], December 2003).

2. Premiums, Deductibles, and Co-Insurance

The monthly premiums would be approximately $35 per month. The annual deductible would be $250. After the initial $250, beneficiaries would pay a 25 percent co-insurance until the initial coverage limit of $2,250 (or a benefit cap of $1,500). Beneficiaries would then pay 100 percent of the costs until they reached the maximum out-of-pocket limit, or catastrophic cap, of $3,600. The "doughnut hole" in this bill would be $2,850. The premiums, deductibles, benefit caps, and out-of-pocket limits were all based on a 2006 start time, and indexed for subsequent years. Figure 4.1 illustrates the benefits and out-of-pocket payments of the final law.

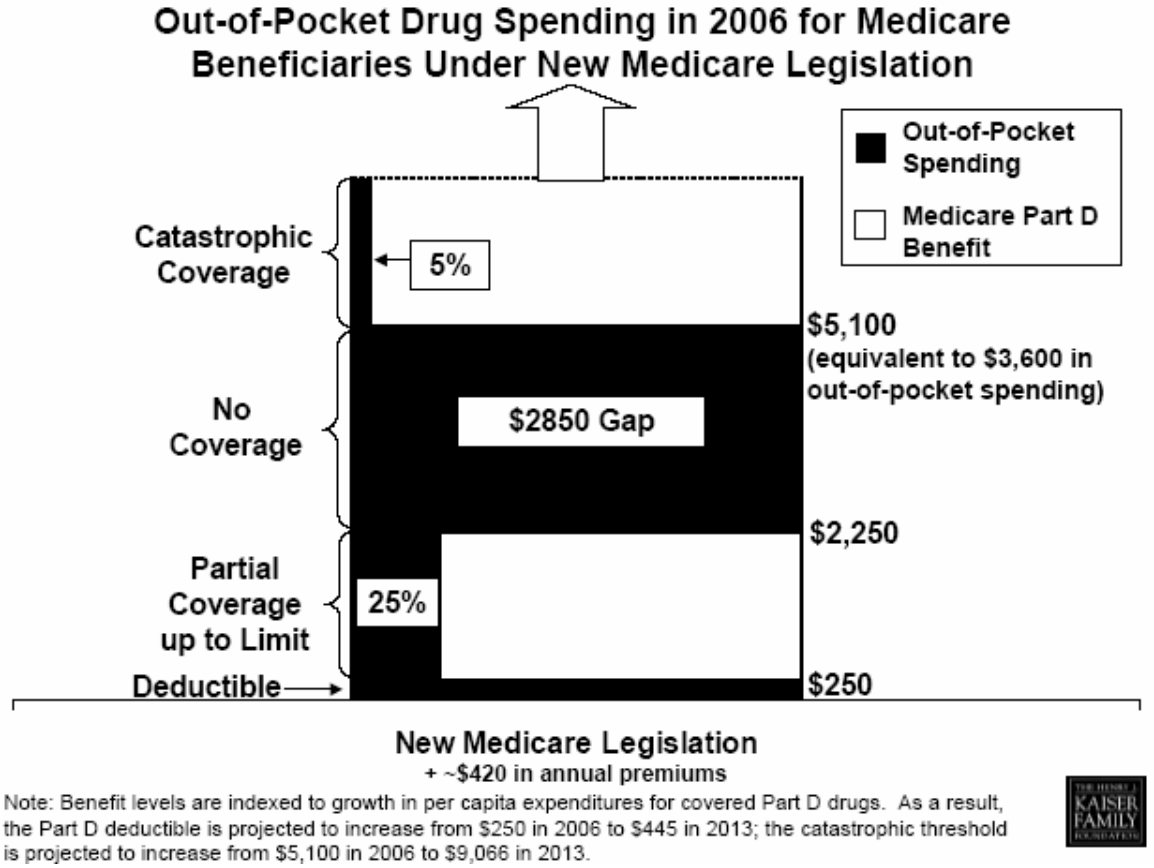

Figure 4.1. Provisions of the Medicare Drug Benefit, Enacted December 2003 (From Kaiser Family Foundation, November 2003).

3. Low-income Provisions

Table 4.3 illustrates the low-income provisions for the new Medicare drug benefit. Those with incomes up to 135 percent of poverty level and limited savings, would not have an annual deductible, nor have to pay monthly premiums for the standard drug coverage. The cost-sharing for those under the 135 percent level would be no more than $2 for generics and $5 for brand-name drugs, up to the out-of-pocket limit of $3,600. Those with incomes below 100 percent of poverty ($9,310 single/$12,490 couple) would be dual eligible for Medicare and Medicaid. The cost-sharing for those under 100 percent of poverty would be $1 and $3 co-pays. There would be no gap in coverage for these beneficiaries, and there would be no co-pay for all prescriptions after the out-of-pocket limit is reached.

Beneficiaries with incomes less than 150 percent of poverty ($13,965 single/$18,735 couple), but greater than 135 percent, would have sliding-scale subsidies for premiums to be determined by the HHS. Their annual deductible would be $50, and cost-sharing would be 15 percent of total drug costs up to the out-of-pocket limit. There would be no gap in coverage, and the co-pay for drugs would be $2 for generic and $5 for brand-name after the out-of-pocket limit had been reached.

The Congressional Budget Office estimated that in 2006 there would be approximately 6.3 million dual-eligible beneficiaries, 5.8 million with incomes below 135 percent of poverty, and 1.9 million with incomes between 135 and 150 percent of poverty. This estimate indicated that one-third of Medicare beneficiaries would be eligible for low-income assistance under the new law.

Premium and Cost-Sharing Subsidy Amounts for Various Subsidy Eligible Groups, in 2006

FPL & Assets*	Percentage of Premium Subsidy	Deductible	Copayment up to out-of-pocket limit	Copayment above out-of-pocket limit
Full benefit dual eligibles	100%	$0	1.Institutionalized individuals-$0. 2. <=100% FPL—The lesser of $1-generic/preferred multiple source or $3-other drugs or, the amount charged to other individuals with income below 135% FPL with assets <=$6,000/<=$9,000. 3. All other full benefit dual eligibles-- $2-generic/preferred multiple source- $5-other drugs.	
<=100% FPL <=$6,000 <=$9,000	100%	$0	$0 institutionalized individuals. For all others, the lesser of $1-generic/preferred multiple source or $3-other drugs or, the amount charged to other individuals with income below 135% FPL with assets <=$6,000/<=$9,000.	None
>100% <135% FPL <=$6,000 <=$9,000	100%	$0	$2-generic/preferred multiple source- $5-other drugs.	None
<135% FPL >$6,000-<=$10,000 >$9,000-<=$20,000	100%	$50	15 percent coinsurance	No more than $2 for a generic or preferred multiple source drug or $5 for other drugs
>=135%-<150% <=$10,000 <=$20,000	Sliding Scale Premium Subsidy (100%-0%)	$50	15 percent coinsurance	No more than $2 for a generic or preferred multiple source drug or $5 for other drugs

* 2006 assets figures are shown for individuals first, and then couples.
** The premium subsidy is equal to the percentage shown in the above table of the greater of the low-income benchmark premium amount or the lowest basic PDP premium in the region. It also cannot exceed the basic premium for drug coverage under the prescription drug plan selected.

Table 4.3. Subsidies for Low-Income Beneficiaries in P.L. 108-173 (From Federal Register, 2004, p. 46731).

Upon passage of P.L. 108-173, the Congressional Budget Office estimated that the prescription drug benefit would cost $410 billion over 10 years, all financed from the Treasury's general fund. According to CBO, 87 percent of beneficiaries would enroll in Part D of Medicare, and nine percent of Medicare beneficiaries would enroll in the Medicare Advantage.

4. Other Provisions and Benefit Changes

Other changes were made to Medicare in an effort to reform the 38-year old program and secure its availability to future beneficiaries. These changes have the potential to be extremely controversial because they represent further means-testing of Medicare benefits.

a. Changes in the Part B Deductible

The Medicare Part B deductible had not been changed since 1991. The new law stipulates that the deductible will increase to $110 in 2005, and will continue to be increased annually by a percentage equal to the annual increase in Part B expenditures. This means that the higher the rate of increase in Part B expenditures, the higher the rate of increase to the Part B deductible (KFF, December 2003).

b. Changes to Part B Premiums

Medicare beneficiaries pay premiums that cover about 25 percent of Part B costs. The other 75 percent is funded by revenues from the Treasury's general fund. The Part B monthly premiums are withheld from beneficiaries' monthly Social Security checks. The Part B premium in 2004 was $66.60, and is a uniform price for all beneficiaries. Each year premiums are increased to reflect general growth in health care costs, such as higher payments to physicians

or privately managed Medicare health plans, and to build trust fund reserves.

In addition to the annual premium increases, beginning in 2007, beneficiaries with higher incomes will have to pay higher premiums. For those with incomes between $80,000 and $100,000, premiums would be 35 percent. Premiums will be 50 percent for those with incomes between $100,000 and $150,000. For beneficiaries with incomes between $150,000 and $200,000, the premium will be 65 percent. For those above $200,000, the premium will be 80 percent. The income thresholds for married couples are double the income amounts described above. CBO estimates that between the years 2007 and 2013, the government will save $13 billion in income-related part B premiums (Kaiser, December 2003).

H. A BILL SURROUNDED BY CONTROVERSY

There were many issues at stake in the fight over the Medicare drug bill. Political groups who represented the interests of their members lobbied Congress heavily during the period that the drug bill was being considered. Most of the controversy revolved around conflicts of interest and campaign donations.

1. Conflicts of Interest

a. AARP

One controversial issue arose near the end of November before the conference agreement had been resolved. During the conference between the House and the Senate, AARP endorsed the Republican version of the Medicare prescription drug bill, H.R. 1. The Democratic congressional leadership (Tom Daschle, Senate Minority Leader, and Nancy Pelosi, House Minority Leader) wrote a

letter to the Chief Executive Officer of AARP, William Novelli, requesting him to justify AARP's backing of the bill. While a poll indicated that the majority of AARP's members did not favor the Medicare bill, the leadership asked that AARP make a commitment not to profit from the sale of discount drug cards, pharmacy benefit plans, or other managed care plans to Medicare beneficiaries in order to "dispel any perception of a possible conflict of interest" (Daschle, Pelosi, 2003).

USA Today reported that AARP's insurance business was roughly one-third of its total income. The political watch dog, Public Citizen, said insurance-related business accounted for 60 percent of the organization's annual revenues. With provisions for private health plans to offer drug-only coverage as well as integrated Medicare plans, AARP could benefit greatly from the House version of the Medicare reform bill as a profit-earning insurance broker.

b. Campaign Contributions

According to the November 24th Capital Eye, a newsletter by the Center for Responsive Politics, Republican House members who voted for the prescription drug bill on November 22nd raised an average of $28,500 from pharmaceutical companies, compared to $8,112 for the Republican lawmakers who voted against the bill. Private health insurers donated an average of $19,286 to House Republicans who voted for the bill, as opposed to $13,828 to those who voted against it. For the Democrats, the "yes" voters received an average of $16,296 from pharmaceutical companies and $22,736 from health insurers, while the Democrats who voted "no" averaged $11,791 and $9,692, respectively (Capital Eye, 2003).

c. Scully's Employment Seeking

After the new Medicare bill was signed into law, Thomas Scully, Center for Medicare and Medicaid Services Administrator, announced that he would be taking a job with a law firm named Alston & Bird, a lobbying firm for health care industry companies, and would work part-time for Welsh, Carson Anderson & Stowe, an investment firm. While Scully was head of CMS, he disclosed to his supervisor, the Secretary of HHS, Tommy Thompson, that he was seeking other employment. According to Public Citizen, a minimum of 41 companies or associations were connected to three of Scully's employment interests and had financial interests in the Medicare legislation. The three firms Scully considered lobbied for approximately 30 companies or associations that were affected by the new Medicare law. Two of the investment firms he had talks with had substantial financial stakes in at least 11 companies affected by the law (Public Citizen, 2003).

2. The Unattainable Cost Estimates

One of the major points of contention of the Medicare bill was the cost. CBO estimated that the Medicare bill, including the drug benefit, would cost $395 billion over ten years. The CMS had an estimate of over $100 billion more, at $534 billion. Lawmakers, however, were not given this information. According to the chief actuary, Richard Foster, he was directed by his boss, Thomas Scully, not to answer any questions from Congress regarding the estimated costs of the Medicare bill, and was threatened to be fired from his job, if he did. If conservatives and moderate Republicans were aware of a cost greater than the $400 billion set aside by Congress, the bill would have had even more difficulty getting the requisite votes to pass.

I. SUMMARY

This chapter focused on the creation, approval, and passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. It discussed the bills introduced in the House and the Senate in 2003 and described the process that the bills followed in each chamber. Also discussed were the major issues that were negotiated between the two bills, and the results of the compromise that was finally reached. Lastly, the chapter covered some of the controversy which surrounded the bill after passage.

Chapter five discusses the fiscal impacts of the final version of the bill and the unfinished business the second session of the 108th Congress faced in 2004.

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V. SUMMARY AND CONCLUSIONS

A. INTRODUCTION

This chapter discusses the accuracy of the cost estimates available to Congress when it passed the Medicare bill, explains the differences between CBO estimates and the estimates made by the Bush Administration, and lawmakers' reactions to information related to the cost of the bill received after it was signed into law. After consideration of the fiscal impacts of the final version of the bill, unfinished business related to Medicare reform and the prescription drug benefit is identified. Finally, the chapter summarizes the main issues in the thesis, and makes recommendations for future research.

B. COST ESTIMATES OF THE MEDICARE BILL

Estimating the costs of open-ended benefits such as prescription drug coverage is loaded with uncertainty. Actuaries are faced with making assumptions on utilization and behavior of groups of people as well as behaviors of the economy and private industry. All this uncertainty, and small changes to assumptions, can create big differences in estimated costs. The difficulty of making assumptions for these variables has been known since the beginning of the Medicare debate in the 1960s. Not only are estimates dependent on the behavior of beneficiaries, but also on the future prices of drugs - many of which have not been developed or marketed – as well as other economic projections (Schuler, 2004, p.750).

One month after the Medicare bill had been signed into law, new estimates were released by the Bush Administration through the HHS and CMS. The estimates were drastically

different than the estimates made by CBO prior to House and Senate agreement on the conference report in November.

1. Estimates by the Congressional Budget Office

The Congressional Budget Office is the entity Congress is obligated to use, by its own rules, to "score" the budgetary impacts of legislation. When the Congressional Budget Resolution was agreed upon in March of 2003, the $400 billion price tag was set, and whatever legislation was agreed upon for the addition of benefits and reform to Medicare, it was required to fall within the negotiated limit.

CBO estimated that the overall cost of the Medicare bill would be $395 billion over 10 years, and the prescription drug portion of that would be $422 billion. CBO estimated savings of $27 billion to offset the higher costs of the drug benefit that would come from changes in Fraud, Waste, and Abuse procedures, Fee-for-Service provisions, cost containment efforts, and faster access to generic drugs.

2. Estimates by the Bush Administration

In January of 2004, the Centers for Medicare and Medicaid Services and Department of Health of Human Services released estimates for the Medicare bill that disagreed with the CBO estimates. The Administration's estimates said the new provisions would cost $139 billion more over 10 years, or more than $534 billion. The disparity caused an uproar between Democrats and Republicans in Congress.

3. Reasons for the Disparity in Estimates

On February 2nd of 2004, CBO provided an explanation of the differences between the Administration and the CBO

estimates. The differences were accounted for in three major areas related to the prescription drug benefit: the participation rate of Medicare beneficiaries in Part D, the participation rate of beneficiaries in low-income subsidies, and savings in the Medicaid program. Another reason for the differences was the anticipated participation rate in the new Medicare Advantage (formerly Medicare + Choice).

a. Participation in Part D

CBO estimated that 87 percent of beneficiaries would participate in the basic Part D benefits, while the Administration assumed 94 percent of beneficiaries would participate. This accounted for a difference of $32 billion in the cost of the basic benefit. CBO estimated that enrollees who currently decline Part B coverage would also not participate in Part D, nor would beneficiaries with more generous prescription drug coverage from the Federal Employees Health Benefits program or Tricare-For-Life (military retiree health care) participate in Part D (Holtz-Eakin, 2004).

b. Participation in Low-Income Subsidy

CBO estimated that participation in the low-income subsidy would increase over a three-year period while the Administration estimated an immediate increase. The Administration also assumed roughly a 15 percent higher participation rate than CBO. CBO based its rate on the current low-income subsidy programs. There was also a difference in the per capita costs assumed by each organization. The Administration assumed a seven to ten percent higher per capita cost than CBO. All of these differences amounted to approximately $47 billion of the $139 billion disparity.

c. Savings in Medicaid

The savings in the Medicaid program assumed by CBO was based on provisions of the Medicare prescription drug benefit that would end the need for Medicaid providing prescription drugs to dual eligible beneficiaries. CBO estimated the savings to be approximately $141 billion, whereas the Administration assumed a $123 billion savings. The difference here was $18 billion.

d. Medicare Advantage (MA) Participation

The Administration assumed a higher participation rate in MA than CBO. CBO estimated only nine percent of beneficiaries would enroll in MA, while the Administration assumed a 32-percent participation rate. This difference in participation rate accounted for a $32 billion cost difference.

All together, CBO's explanation accounted for $129 billion of the $139 billion difference between the cost estimates. The assumptions that each organization made are legitimate, but the uncertainty makes the assumptions particularly difficult to depend on. Until the new benefit is implemented, there is no completely error-free estimate of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

C. UNFINISHED BUSINESS AND CONCLUSIONS

Soon after the Medicare bill was signed into law, legislation intended to change it was introduced in the House and the Senate. The 2nd session of the 108th Congress was faced with more attempts to correct what some lawmakers thought were the shortcomings of the Medicare bill in 2003.

This legislation addressed various issues, including direct negotiations by the Secretary of HHS with

pharmaceutical manufacturers, pharmacies, and prescription drug plans to obtain the best price for prescription drugs for Medicare beneficiaries by using its volumetric leverage. Additional legislation would allow the reimportation of drugs from certain pre-approved industrialized countries in order to save consumers and the government money. The House version of the Medicare bill in 2003 had language that would have allowed reimportation, in hopes of winning GOP votes, but the provision was dropped in conference.

More discontent in the Medicare law came from oncologists, whose physician-dispensed cancer treatment reimbursement would be affected by the legislation. New legislation introduced in late 2003 and in 2004 would provide an opportunity to change the law for these providers.

It became clear during the evolution of the legislation for Medicare reform and prescription drug coverage that there were many interests that would be affected by legislation. Every aspect of the Medicare program, providers, consumers, as well as private industry, was affected by the Medicare law of 2003. Achieving a positive outcome for one group would negatively affect another group. Creating legislation that would appease all of the stakeholder groups would be impossible. The result was a benefit with gaps, which would provide help to some, but not to others, but still cost the general tax-paying public over $400 billion, in addition to beneficiaries' out-of-pockets costs.

D. CHAPTER SUMMARY

The primary purpose of this thesis was to discuss the major policy compromises underlying the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the major problems that have been identified subsequent to the passage.

Chapter I provided an introduction to the thesis, discussed the goals, and the methodology used to achieve them. Chapter II provided background on the Medicare program, the issues lawmakers were required to consider, and long-term problems and uncertainties in health care reform and the prescription drug issue. Chapter III introduced attempts made to reform the Medicare program to include prescription drug benefits, and explained the roles played by partisan politics and special interest groups in the legislation. Chapter IV focused on the process the legislation followed in 2003, discussed the major compromises that were made, and provided an overview of the major provisions of the final legislation. This chapter also discussed the problems and controversy that followed from the passage of the Medicare legislation. Chapter V addressed the problems with the cost estimates of the Medicare legislation, explained the uncertainty involved, and introduced the problems that are being addressed in the second session of the 108th Congress.

E. RECOMMENDATIONS FOR FURTHER RESEARCH

Future research consideration should be given to the impacts of new legislation on the Medicare program, the true benefit realized by Medicare beneficiaries based on level of income and annual drug expenditures, and, once the

Medicare prescription drug benefit is implemented, actual costs incurred by the new coverage added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

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APPENDIX

Chronology of Legislative Events in 2003 Associated With Passage of the Medicare Prescription Drug Benefit

Date	Event
07 January	Rep. Capito (R., W.Va.) introduced H.R. 38 to provide for a voluntary Medicare outpatient prescription drug benefit program. Bill subsequently died in subcommittee.
	Senator Daschle (D., SD.) introduced S. 7 to provide coverage of outpatient prescription drugs under the Medicare program and to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals. Bill subsequently died in committee.
28 January	President Bush declared intention to provide a prescription drug benefit under Medicare in his State of the Union Address.
03 February	Congress received President Bush's FY04 budget proposal which included $400 billion over ten years for Medicare modernization and addition of a prescription drug benefit.
04-05 February	Senate and House Budget Committees took testimony from OMB Director on the President's FY04 budget proposals.
06 February	House Ways and Means Committee took testimony from HHS Secretary on the President's FY04 budget proposal regarding Medicare reform.
13 February	House Ways and Means Committee (Subcommittee on Health) heard testimony on "Medicare Regulatory and Contracting Reform".
25 February	House Ways and Means Committee (Subcommittee on Health) heard testimony on "Eliminating barriers to Chronic Care Management in Medicare".
26 February	Senate and House Budget Committees took testimony on Medicare reform from HHS Secretary on President's FY04 budget for the Department of HHS.
27 February	Senate Committee on Finance took testimony from HHS Secretary on the Administration's FY04 Health Care Priorities
03 March	Rep. Engel (D., NY.) introduced H.R. 1045 to provide for coverage of outpatient prescription drugs under part B of the Medicare Program. Bill subsequently died in subcommittee.
04 March	President Bush announced his Framework to Modernize and Improve Medicare in a conference with the members of the American Medical Association.
06 March	House Ways and Means Committee (Subcommittee on Health) heard testimony on the "MedPAC Report on Medicare Payment Policies".
12 March	House Budget Committee marked up FY04 budget resolution (H.Con.Res. 95)

which added language requiring joint resolution or conference agreement to be passed in order to allocate funds for Medicare reform and the addition of a prescription drug benefit.

12 March — Introductory remarks were heard on measure H.R. 1199 to provide for a voluntary Medicare prescription medicine benefit and greater access to affordable pharmaceuticals, in House Ways and Means-Subcommittee on Health. Bill subsequently died in subcommittee.

12-13 March — Senate Budget Committee marked up FY04 budget resolution (S.Con.Res. 23) which included language requiring a joint resolution or conference agreement to be passed in order to allocate funds for Medicare reform and the addition of a prescription drug benefit.

21 March — H.Con.Res. 95 agreed to in the House by a vote of 215-212.

26 March — S.Con.Res. 23 agreed to in the Senate by a vote of 56-44.

01-10 April — House and Senate conference on Budget for FY04.

02 April — Rep. Dooley (D.,Cal.) introduced H.R. 1568 to provide for a prescription drug benefit for Medicare beneficiaries. Bill subsequently died in subcommittee.

03 April — Senate Committee on Finance heard testimony on “Purchasing Health Care Services in a Competitive Environment.”

08-09 April — House Energy and Commerce Committee (Subcommittee on Health) held hearings on “Designing a Twenty-First Century Medicare Prescription Drug Benefit” and “Strengthening and Improving Medicare.”

09 April — House Ways and Means Committee heard testimony on “Expanding Coverage of Prescription Drugs in Medicare.”

10 April — Rep. Crowley (D., NY.) introduced H.R. 1733 to provide for a voluntary Medicare prescription medicine benefit. Bill subsequently died in subcommittee.

11 April — House agreed to conference agreement on the Congressional Budget Resolution for FY 2004 (H.Rept. 108-71) by a vote of 216-211; Senate agreed to conference agreement by a vote of 51-50.

01 May — House Ways and Means Committee (Subcommittee on Health) heard testimony on “Medicare Cost-Sharing and Medigap.”

06 June — Senate Committee on Finance heard testimony on “Strengthening and Improving the Medicare Program.”

11 June — Senators Frist (R., Tenn.) and Baucus (D., Mont.) introduced S. 1, a bipartisan measure, to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program.

12 June — Rep. Sanchez (D., Cal.) introduced H.R. 2461 to establish a Medicare prescription drug benefit covering costs that exceed a percentage of a beneficiary's income. Bill subsequently died in committee.

12 June	Rep. Terry (R., Neb.) introduced H.R. 2469 to provide under Medicare a health care program similar to that for Federal employees under the Federal Employees Health Benefits Program (which includes prescription drug benefits). Introductory remarks were heard, but the bill subsequently died in committee.
12 June	Senate Committee on Finance held mark up session to consider S. 1, The Prescription Drug and Medicare Improvement Act of 2003. Committee approved the bill by a vote of 16-5.
16 June	Representatives Thomas (R., Cal.) and Tauzin (D., La.) introduced H.R. 2473 to provide for a voluntary program for prescription drug coverage under the Medicare Program and to modernize the Medicare Program. Bill referred to Ways and Means and Energy and Commerce Committees.
17 June	Rep. Sanders (I., Vt.) introduced H.R. 2498 to provide a prescription drug benefit program for all Medicare beneficiaries. Bill subsequently died in committee.
17 - 19 June	H.R. 2473 referred to the House Energy and Commerce Committee for Full Committee consideration and mark up. Committee agreed to the bill by a vote of 25-15. H.R. 2473 renamed H.R. 1.
18 – 26 June	Senate considered S. 1 with amendments.
24 June	Rep. Burr (R., NC.) introduced H.R. 2578 to establish a voluntary Medicare outpatient prescription drug discount and security program. Bill subsequently died in committee.
25 June	Rep. Thompson (D., Cal.) introduced H.R. 2606 to provide prescription drug coverage under the Medicare program and to make improvements in Medicare payment for rural providers. Bill subsequently died in committee.
26-27 June	House considered H.R. 1 (Medicare Prescription Drug and Modernization Act of 2003). H.R.1 passed House by a vote of 216-215.
27 June	Senate passed S. 1 by a vote of 76-21.
14 July	House and Senate began conference to resolve differences between House- and Senate-passed Medicare reform bills.
21 November	Conference Agreement (H.Rpt. 108-391), Medicare Prescription Drug, Improvement, and Modernization Act of 2003, received by House and Senate.
22 November	House passed H.Rpt. 108-391 by a vote of 220-215.
25 November	Senate passed H.Rpt. 108-391 by a vote of 54-44.
08 December	President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.

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